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ABSTRACT

The workshop was attended by 72 participants representing a variety of health agencies. The disciplines they represented included medicine; nursing, hospital, and public health; psychology; nutrition and dietetics; social work; rehabilitation; occupational, physical, and speech therapy; volunteer and juvenile service work; counseling; training; health education; and health advocacy. The goal of the workshop was to provide guidelines and assistance for the development and refinement of specific patient education plans in a variety of health settings in the State. Eight speeches were presented concerning the concept of patient education, program planning, communication, educational methods and materials, cost effectiveness and evaluation. Group sessions were conducted in between plenary sessions. Each of the 23 multidisciplinary teams developed plans for selected target populations. Summaries of their reports indicate: the desirability of using a variety of educational methods and materials, the need for staff training, and the techniques for evaluating the success of the educational efforts. (AG)

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Proceedings...

Workshop on Patient Education Programing

April 30 to May 3, 1973
MARRIOTTSVILLE SPIRITUAL CENTER
Marriottsville, Maryland

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service
Health Resources Administration

April 30 to May 3, 1973
MARRIOTTSVILLE SPIRITUAL CENTER
Marriottsville, Maryland

Sponsored by:

MARYLAND STATE DEPARTMENT
OF HEALTH AND MENTAL HYGIENE
Educational Services

In cooperation with:

- ☐ Maryland Regional Medical Program
- ☐ Maryland Hospital Association
- ■ Health Care Facilities Service
  Health Resources Administration
  U.S. Department of Health, Education, and Welfare

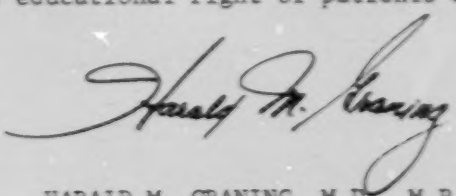
foreword

In keeping with the Hill-Burton program's long-standing commitment in both national and international activities in the field of patient education, we were indeed pleased to cooperate in sponsoring the Maryland Workshop on Patient Education Programing.

Because we feel that the activities at that workshop will be of widespread interest to health educators and other health professionals throughout the Nation, we undertook the task of developing and publishing this document. Much of the material contained in the speeches and summaries of program plans should be of special interest to those who may wish to use this workshop as a model for similar conferences.

Miss Joan Wolle, Chief, Educational Services, Maryland State Department of Health and Mental Hygiene, has been most generous in her acknowledgments, but her personal commitment contributed a great deal to making the workshop possible.

It is our hope that the concept of patient education as a part of high quality care will be developed with and for each patient who can learn in every hospital and health care facility. This report should help to acquaint readers with some of the philosophy, problems, and program activities that persons involved need to know about this educational right of patients and their families.



HARALD M. GRANING, M.D., M.P.H.
Assistant Surgeon General
Director
Health Care Facilities Service

preface

As a further impetus to patient education, we are pleased to present the Proceedings of the Maryland workshop on Patient Education Programing, sponsored by the Maryland State Department of Health and Mental Hygiene, April 30-May 3, 1973, at the Marriottsville Spiritual Center, Marriottsville, Maryland.

The goal of the workshop was to provide guidelines and assistance for the development and refinement of specific patient education plans in a variety of health settings in the State.

The workshop consisted of plenary sessions interspersed with group work sessions. Topics at the plenary sessions included the concept of patient education, program planning, communication, educational methods and materials, cost effectiveness and evaluation.

Attending were 72 participants representing a variety of health agencies including local health departments, general hospitals (inpatient and outpatient services), tuberculosis and chronic disease hospitals, nursing homes, and a juvenile training school. Participants came as members of multidisciplinary teams from the health facilities. The disciplines represented included medicine (psychiatry and orthopedic surgery); nursing, hospital and public health; psychology; nutrition and dietetics; social work; rehabilitation; occupational, physical, and speech therapy; volunteer and juvenile service work; counseling; training; health education; and health advocacy.

Like the participants of the workshop, the speakers and panelists were also from a variety of disciplines; they included physicians, nurses, health educators, pharmacists, a nutritionist, program administrators, and fiscal experts. For the work sessions, several teams were grouped together with one or two leaders, who served as group facilitators and consultants in patient education programing.

The workshop's main objective was for each of the 23 multidisciplinary teams to develop educational plans for their selected target populations. (Summaries of the reports of these teams have been incorporated in this publication.) The plans indicate the desirability of using a variety of educational methods and materials, the need for staff training, and the techniques for evaluating the success of the educational efforts.

For many, this was the first opportunity for different disciplines to work together in an intensive workshop setting toward developing a specific comprehensive educational program for a target population. Despite the hurried pace and the lure of the pleasant environmental site of the workshop, the teams were enthusiastic, working from early morning until late at night to complete their tasks. For most, the variety of facilities represented by the participants, as well as disciplines, enhanced the value of the workshop experience.

From its conception, the workshop was visualized as a first, not an end, step. Successful as it was, the workshop must be regarded as only a beginning because the plans must be implemented even though perhaps in some cases considerably revised. Convening again in late October 1973, the participants will share reports of the progress of their programs, discuss problems as well as resources, and plan for further development of the patient education program in health facilities where they work.

It is hoped that the Maryland State Department of Health and Mental Hygiene, by assuming the leadership in patient education programing, will be promoting a higher quality of health care for all people in the State. Other health agencies may also find a multidisciplinary workshop an effective springboard to a comprehensive approach to effective patient education programing; and assuredly many health care facilities will find the multi-disciplinary approach to patient education not only a challenging but a rewarding approach.

Joan M Wolle

JOAN M. WOLLE
Chief, Educational Services
Maryland State Department of
Health and Mental Hygiene

acknowledgments

It was because of the assistance of several organizations and a number of people combined with the enthusiasm of the participants that the Maryland Workshop on Patient Education Programing was a success.

We are indebted to the three organizations which cooperated with the Maryland State Department of Health and Mental Hygiene in conducting the workshop: Maryland Regional Medical Program; Maryland Hospital Association; and Health Care Facilities Service, Health Resources Administration, U.S. Department of Health, Education, and Welfare.

Through a grant from the Maryland Regional Medical Program, it was possible to offer stipends to a number of participants who might otherwise not have been able to attend. Special appreciation is expressed to Dr. Edward Davens, Coordinator of Maryland Regional Medical Program, for his interest and support of the project.

In addition to providing professional and technical assistance, the Health Care Facilities Service arranged for the participation of several of the speakers and group leaders. From the Office of Education and Training of that unit, Miss Ruth F. Richards, Director; Mr. Stanley Rosenberg, Assistant Director; and Miss Evelyn Starks, Education Specialist, were especially helpful. They assisted in planning the workshop and played various roles during the conference such as moderator during plenary sessions and they also served as group leaders. Special commendation is due HCFS's Office of Information and Technical Publications, which was responsible for printing the announcements and program and for editing and producing these proceedings. This document is both an excellent record of the workshop for the participants as well as a reference for other readers interested in patient education and especially those interested in planning similar workshops.

Speakers and panelists whose talks appear in this publication deserve special thanks. Two of the speakers-- Miss Elizabeth A. Lee and Miss Anna W. Skiff--also served as group leaders. Other group leaders who should be recognized for their special contributions are Miss Virginia Fernbach, Health Education Consultant, Health and Welfare Division, Metropolitan Life Insurance Company, New York, N.Y., and Mr. Roswell F. Jackson, Jr., Staff Associate, Division of Education, American Hospital Association, of Chicago, Ill.

One individual who deserves very special kudos is Miss Jennifer Young, Community Health Educator, Maryland State Department of Health and Mental Hygiene, who served as the Assistant Coordinator and was responsible for much of the planning and implementation.

Finaily, it was the participants who truly made the workshop. Each person--as an individual and as a member of a team--made a unique contribution.

The workshop was a valuable personal and professional learning experience. One can be proud of the dedication of those in the health field who do indeed care about the patient. I personally was inspired. With the abilities, the concerns, and the dedication expressed at the workshop, there can be excellence in patient education programing, resulting in both humantarian and financial benefits for both the consumers and providers of health services.

J. M. W.

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Keynote Address: Monday evening, April 30, 1973

PATIENT EDUCATION IN CONTEMPORARY HEALTH SERVICE DELIVERY

*Edyth H. Schoenrich, M.D., M.P.H.**

DEFINITIONS

The words health education are variously used to refer to a broad spectrum of activities ranging from the simple provision of public information to elaborate programs for training highly specialized health manpower. For our purposes in this workshop, the definition most useful to us is the one used by the President's Committee on Health Education appointed in September 1971. This definition states, "Health education is a process that bridges the gap between health information and health practices."

Within the broad spectrum of health education our specific concern in this workshop is with patient education. This is a process which begins with the imparting of factual information to patients, but which also includes interpretation and integration of the information in such a manner as to bring about attitudinal or behavioral changes which benefit the individual's health status. Thus, it is clear that patient education not only involves the world of medical scientific facts, but in its process is also closely interwoven with psychology, sociology, behavioral science, and cultural anthropology.

An organized program for patient education involves a systematic effort on the part of one or more health professionals in a health service delivery setting. It consists of a number of orderly steps which include assessing the patient's own knowledge about his health; determining the patient's health educational needs; the provision of information in a manner most understandable and acceptable by the patient; assuring so much as is possible that this information is integrated into the patient's attitudes; and, finally, a follow-up to assure that the new information has indeed produced behavioral changes with beneficial effect upon the individual. This process frequently must be directed not only toward the

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patient himself but also to other individuals of key significance in the patient's life pattern. Not only scientific facts, but also the facts of human motivation and behavior as well as information concerning the cultural setting and background of the patient must all be incorporated in the process for successful communication. Furthermore, it is often true that health service delivery staff need to participate in health education themselves before they can design and implement a successful organized program for patient education.

IMPORTANCE OF PATIENT EDUCATION

Increased Emphasis upon Prevention--One of the major thrusts in the evolution of our contemporary health service delivery system appears to be an increased emphasis upon the prevention of disease processes, illnesses, and impairments. This includes primary prevention which refers to the prevention of the occurrence of disease, secondary prevention which refers to early recognition and intervention in disease processes, even at a stage in which they may still be unrecognized by the patient, and tertiary prevention which requires highly specialized medical and surgical care including rehabilitation services. Our Nation is becoming increasingly sensitized to the enormous human and resource costs of chronic and catastrophic illness, with increasing attention on "what might have been, if only" these problems could have been prevented.

In the first half of this century in the United States we have achieved increasingly effective control of the infectious and communicable diseases. This was done through primary prevention of these diseases by the mechanisms of immunization and environmental control. The development of antibiotics in the 1930's and 1940's contributed to this control. Attention is now increasingly centered on the prevention of chronic diseases and catastrophic illness. Though we lack scientific information for primary prevention of many of these problems, think for a moment how much it means, not only to a patient and his family but also to society as a whole, to be able to prevent the human and resource costs of these diseases. Think for a moment of what it means to prevent a stroke through the sometimes simple approach of controlling hypertension. Think of what it means to prevent the personal catastrophe of paraplegia resulting from a spinal cord injury due to drunken driving. Think what it means to prevent the painful death of a man in his prime from cancer of the lungs through control of smoking. Think what it means to prevent the amputation of a gangrenous leg in an elderly diabetic through good total personal hygiene and health care. Think what it means to prevent the problems of overcrowding and malnutrition through thoughtful and compassionate family planning.

Success in all of these endeavors must include well-organized patient education programs.

Increasing Incidence and Prevalence of Chronic Illness and Aging Problems--As the incidence and prevalence of communicable diseases have been brought largely under control, the problems of birth defects, accidents, chronic illnesses, and aging have come to the fore. With the exception of traumatic accidents, these health problems have slow insidious onset, tend to be of long duration, tend to disable many months or years before they kill, tend to require continuing care, sometimes for life, because of their long-term nature, and, finally, tend to have enormous psycho-social and financial impact upon the patient, his family, and society as a whole, because of the long term needed for complex services.

Another feature of chronic illness which is of special importance to those of us interested in patient education is the fact that the low-grade, long-term features of chronic illness mean that the major portion of the management of a chronic illness rests in the hands of the patient himself or his family, rather than in the hands of health professionals. Of course, the intervention of health professionals and health facilities such as hospitals are essential to make proper diagnoses and to elaborate plans for management. However, most of the day-to-day management of this type of health problem is in the patient's own hands. Think for a moment of the diabetic who must daily manage his own food intake and medication. Think of the patient with healing tuberculosis who now has an average of only 90 days in the hospital after which he must carry through another 21 months of daily therapy himself with only intermittent contact with health professionals in order to assure that no reactivation occurs. Think of the cardiac patient or the hypertensive who must manage his own medications and pace himself, perhaps with major changes in life pattern, in order to maintain his health. Think of the individual with an amputation or a spinal cord injury due to a traumatic event who then must every day of his life live with, adjust to, and manage his impairment. Think of the family that cares on a day-to-day basis for a child with cerebral palsy. The staggering increase in the importance of the role of the patient and his family in the management of individual health problems is something which demands effective patient education services.

Increasing Costs of Health Services--Another social force which is moving us toward increased emphasis upon patient education is the escalation of costs for health services. Last year over $75 billion were spent on health care. Approximately 7.5 percent of the gross national product of the United States was spent on health care this year. The public is generally aware that hospitalization which only a few years ago averaged $50 to $75 per day in large cities may now average $100 to $150 a day. The health industry employs over 4,500,000 persons including both professionals and support personnel. In terms of manpower, the health industry is therefore the third largest industry in the United States.

This phenomenon in our society is forcing both consumers and providers of health services to be increasingly thoughtful about maintenance of health and the efficient utilization of the health service system. In many instances health problems which are cared for on an inpatient basis could be at least in part managed through ambulatory services. In many instances more effective compliance with a health regimen would prevent costly readmissions to hospitals.

Problems of Health Manpower --Another major problem in health service delivery consists of the deficits and maldistribution of health manpower. Our society is making earnest attempts to meet this problem through a variety of channels, including training of new categories of health personnel and reallocation of responsibility for health tasks. However, an important factor which we must not overlook is the fact that because of the responsibility of the individual citizen in the maintenance of his own health and the increasing role of the patient in the management of his own long-term illness, the citizens of our country can be said to be our greatest source of untapped health manpower. Patient education can make it possible to tap this enormous pool of health manpower effectively.

IMPLEMENTATION OF PATIENT EDUCATION PROGRAMS

Within the context of the concept that patient education must always move beyond the acquiring of factual information to the actual behavioral change, the implementation of patient education programs can be discussed from the viewpoint of target populations, objectives, and process.

Target Populations--Nationwide there are several special populations which can be identified as having unique health needs requiring special emphasis on patient education. These target populations include those to whom preventive services or long-term management are of special significance. These are women of childbearing age, pregnant women, those middle-aged individuals at high risk for chronic diseases, low income groups, and those already chronically ill or suffering from the problems of aging.

Objectives--There are at least four broad areas in which patient and public education is increasingly critical for the efficient and effective operation of our health service system.

(1) There is increasing public awareness and concern for the pollution of our air and water for the presence of hazardous agents such as radiation, pesticides and toxic inhalants and the relationship between exposure and the causation of disease and disability. Society is making serious strides forward in this area.

(2) In the field of personal health maintenance, we intrude into personal and cultural behavior patterns of nutrition, exercise, use of intoxicants including alcohol, drugs, and tobacco, as well as a relaxed and unreal attitude toward the hazards of accidents.

(3) The knowledge of the consumer public about their rights and the benefit packages of various health care systems is essential in making it possible for consumers to use health services in an efficient and effective way rather than in a wasteful way.

(4) The compliance of patients in carrying through with health service advice is often critical for favorable outcomes. In care contacts the literature on patient compliance is enormous and many studies have been done in many types of settings concerning the accuracy with which patients understand directions which are given them by health personnel and the conscientiousness with which they carry out the advice given. Some of the studies are shocking in their demonstration of the insensitivity of our health personnel to the personal and intellectual needs of patients for understanding. Some of the studies are frightening by the frequency with which critical medications are omitted or taken incorrectly.

Process of Patient Education--The process of patient education must at least be concerned with the site, the responsible personnel, and the interrelationships between consumers and health personnel.

Patient education is a process which can go on in any health delivery setting. Because of the usual frequency of hospital utilization for health care, this is a natural setting. In the United States there are perhaps over 7,000 hospitals and yet only about 50 of those have what could really be called organized patient education services. The President's Committee on Health Education has urged that patient education services be available not only in in-patient settings, but also in ambulatory settings including the individual physician's office. The sensitive, thoughtful physician automatically carries out good patient education, but in the future it may be necessary for both individual physicians and those practicing in an organized setting to develop more varied and systematic methods of patient education. For example, a group of internists might set up a series of group sessions for patients concerning the problem of hypertension and its management. The President's Committee has also recommended that both industry and labor become concerned with health education by way of maintaining the health of our working population.

By tradition, patient education has been assumed in the past to be the responsibility of the physician. However, with the changing roles and responsibilities of various categories of health personnel, it has become increasingly clear that patient education is the responsibility of all health personnel who have direct patient contacts. This is especially true, for example, in the instance of a chronic illness, such as a stroke. In this situation the physician plays a less important role once the diagnosis and treatment plan are established--much less important than do the nurses' aides who deal daily with the patient many hours each day. In this situation, it is the nursing and rehabilitation personnel who bear the major responsibility for patient and family education.

In 1959 Drs. Thomas Szasz and M.H. Hollender in an article in the Archives of Internal Medicine presented a description of three categories of doctor/patient relationships. Dr. Richard Magraw has picked up on this and elaborated the concept which is relevant to the field of patient education. These three types of doctor/patient relationships are as follows:

1. Activity-Passivity

   In this type of situation the patient is partially or completely helpless and is unable to make a major contribution to his own care or to decisions concerning it. In this sort of situation the physician does something to or for the patient, with little participation on the patient's part. Examples of this sort of problem are coma, delirium, or severe traumatic accidents and shock. In these instances, the relationship of the doctor to the patient resembles somewhat that of a parent to a helpless young infant.

2. Guidance-Cooperation

   In this model of the doctor/patient relationship the illness may be acute, but is not as overwhelming or as desperate as in the first model. The patient may be keenly aware of what is going on, able to exercise some judgment, and capable of following some directions. However, the situation is usually still serious enough so that advice from the physician is paramount and acceptance of this advice and appropriate follow-through is expected on the part of the patient. In this model the prototype is the relationship of a parent and a child, youth, or adolescent.

3. Mutual Participation

   This model of the doctor/patient relationship is most characteristic of the management of chronic illnesses and the problems of aging. In this situation the major portion of the management of the problem is carried out by the patient himself, with only

occasional consultation or direct contact with a physician. The prototype of this type of relationship is that of consenting adult to adult. One has specialized knowledge to give, but the other uses it voluntarily with understanding, agreement, and acceptance.

CONSTRAINTS

Dr. Scott K. Simonds, on the faculty of the University of Michigan School of Public Health and a member of the President's Committee on Health Education, has pointed out that any new major development in the health field takes an average of 25-30 years for fruition. Health education has a few more years to reach this time limit for general acceptance, but he feels that it is well along the way.

One of the important inhibiting factors has been the lack of a central Federal agency with authority for development of health education. The President's Committee is therefore recommending that an Institute on Health Education be established at the Federal level for this purpose.

Another constraint in the development of patient education programs has been the lack of trained health education manpower. It is my understanding that at the present time in the United States there are only about 25,000 professionally trained health educators. More are needed. Furthermore, through sessions such as the one we are now opening, there must be ways found to increase the participation of all health personnel in the health education and patient education process.

Still another deterrent has been the lack of funding for health education programs. Many third party payors do not include health education or patient education costs in their reimbursement formulas.

SUMMARY

In the context of the many social forces contributing to the present rapid evolution of the system for the development of health services in the United States, professional, systematic patient education must play an increasingly important role. This will help to assure more efficient and effective utilization of our health services, more efficient use of health manpower, increased cost control, and closer cooperation between consumers and the deliverers of health services. In President Nixon's health message to the Ninety-Second Congress in February of 1971 he said, "In the final analysis each individual bears the major responsibility for his own health. Unfortunately, too many of us fail to meet that responsibility. Too many Americans eat too much, drink too much, work too hard, exercise too little, and too many are careless drivers. These are personal questions to be sure,

but they are also public questions, for the whole society has a stake in the health of the individual. Ultimately, everyone shares the cost of illness and accidents--through tax payments, through insurance premiums."

The greater understanding of patient education as a process and broader implementation of its principles on the part of all health service personnel will increase the thrust toward considering each patient as an individual human being, with unique psycho-social, family, and cultural background who deserves the right to have information concerning his health and guidance in using that information to his greatest advantage.

###

Toward Cost-Benefit Evaluations of Health Education: Some Concepts, Methods, and Examples

*Lawrence W. Green**

While I do not believe that health education should have to be justified in economic terms, I do believe that it can and in these times, unfortunately, it appears that it must be in order to survive.

The philosophical dilemma is resolved partly, however, when we find that most of the medical and economic terms in which the benefits in cost-benefit analysis are measured, turn out in the final analysis to be essentially humanitarian terms. The problem, nevertheless, in cost-benefit analysis is as much with decisions about appropriate inputs or numerators and standards of acceptability for those numerators as with outcomes or denominators. In a cost-benefit ratio, for example, the cost of an educational program may constitute the numerator. The problem becomes then: by what standard do we judge the appropriateness of that cost against an alternative cost that would yield the same ratio?

EVALUATION REDEFINED

I should begin by defining evaluation. The proposed definition then is the comparison of an object of interest against a standard of acceptability. This definition identifies the three fundamental elements of any evaluation; namely, the isolation of an object of interest, comparison, and the determination of a standard of acceptability.

In this paper, I shall identify appropriate objects of interest for evaluation in health education, some comparison measures that seem possible and desirable in relation to each of these objects of interest, and finally, five standards of acceptability implicit in different evaluations.

*Associate Professor, Head of Health Education Programs, Johns Hopkins School of Hygiene and Public Health, Baltimore, Maryland.

Objects of Interest in Health Education

In this discussion I would like to work backwards in a causal chain from the health problem to the specific educational techniques or methods employed to deal with the problem. Between these two points in the causal chain are several identifiable, intervening variables or sets of variables, which I shall refer to as factors, each of which may constitute an object of interest for evaluation of health education. Any one of these points in the causal chain, or the continuum, may constitute the dependent variable in an evaluation.

The health problem should be viewed as having one or more behavioral problems. Before one can determine what those problems are, however, one must do a rather thorough analysis of the health problem. Thus, the diagnosis and identification of the health problem is the first object of interest.

For purposes of program planning in patient education, one calls first upon epidemiological information for purposes of identifying the behaviors that may contribute to the health problem. In cancer, for example, epidemiological information provides some clues as to specific behavior such as smoking and early diagnosis that may contribute to the prevention or cure of cancer. In identifying the health problem as the object of interest, it is necessary to make a distinction between preventive, therapeutic, or rehabilitative concerns with the health problem. As the primary object of interest, then, the health problem must be defined both as a disease entity or condition and in terms of the objective one has for planning in relation to that problem. If the purpose for planning is to prevent the problem, then the object of interest is the prevention of the specific disease or condition. Planning may be concerned alternately with the cure for specific cancers or the rehabilitation of people who have had specific cancers.

Having identified and analyzed the health problem as the first object of interest, one then moves backward in the causal chain to the behavioral problems that contribute to the health problem. The behavior in question may be the utilization of specific health services, devices, or products; abstinence from the use or consumption of other products; or the active conduct or support of certain personal, family, or community activities or programs.

For each behavior identified as important in relation to the health problem, one can then work back to a set of factors that contribute to the behavior. I would propose classifying such contributing factors under three general headings: enabling factors, predisposing factors, and reinforcing factors.[1] Under enabling factors are included the availability

1/ This classification represents a slight modification of one proposed by Ronald Andersen, A Behavioral Model of Families' Use of Health Services. (Chicago: University of Chicago Center for Health Administration Studies, Research Series No. 25, 1968).

and accessibility of specific resources necessary to take the behavior in question. Under predisposing factors are included those social and psychological forces that predispose an individual or a group to take or not take the action in question. These might include attitudes, values, beliefs, knowledge, social norms, cultural taboos, and a host of demographic factors including age, socioeconomic status, and family size. This paper will not be primarily concerned with the latter set of demographic factors, because these are not directly changeable in the context of health education.

Under reinforcing factors, I would include those influences over which a health professional or a staff of professionals have some control in determining whether a given action on the part of the patient or consumer population is rewarded or punished. Having thus classified the forces influencing the behavioral problem, I have then suggested three major aspects of educational planning, each of which is primarily directed at the manipulation of one of the sets of behavioral influences. The three educational components are community organization, which is directed primarily at influencing the enabling factors; communications, which are directed primarily at influencing the predisposing factors; and staff development, including inservice training, continuing education, supervision, and consultation, all of which are directed primarily at influencing the reinforcing factors. Note that the reinforcing factors are located primarily in the behavior of providers.

Now, obviously, each of these educational components has a contribution to make to the other sets of factors influencing behavior. Community organization, for example, may be an essential component of a staff development program if an inservice training program requires inter-agency relationships or the development and mobilization of resources for training purposes. Communications very clearly can be seen as an essential element in community organization as well as in training, supervision, and consultation. All that I have suggested here is a simple typology of educational components in a total program according to the factors influencing behavior to which the educational components are <u>primarily</u> directed.

Moving back to the next step in the causal chain, the <u>program</u> should be designed to combine the educational components along with certain organizational, administrative, economic, logistical, manpower and financial considerations, into some kind of sequence that is both realistic and efficacious. The program then, as an object of interest, consists of more than the sum of the parts, the parts being community organization, communication, and staff development along with other elements of a total program. The program consists of the organization and sequencing of the parts. The program may be an object of interest for purposes of evaluation when it is the total program as a package that is under scrutiny and subjected to some kind of comprehensive evaluation.

Moving back yet one further step in the causal chain, one can identify specific educational methods and techniques each of which may alone, or in combination with others, constitute separate objects of interest for evaluation. These include specific media that may be used to transmit educational experiences or communications. The communications themselves, in the sense of the messages conveyed and the appeals used in relation to each message, may be the object of interest in an evaluation. In the case of the community organization component, the personnel who serve as the organizers or the coordinators or the liaison people providing linkages between agencies may be the object of evaluation. In the case of the communications component of the program, one may evaluate the personnel who are the senders of messages or the transmitters of messages who may serve as screens or gatekeepers between the source and the receivers. In the staff development component of a program, the personnel who may be the objects of interest for evaluation are the supervisors, the trainers, or the consultants.

Specific media that may be objects of interest in the evaluation of patient education programs include pamphlets, films, video-tapes, flip charts, or other aids used in communications. The following question should be posed in the evaluation of media as the object of interest: "Is this medium achieving the desired result?" The desired result will be discussed under "Measures of Comparison" and "Standards of Acceptability."

In every communication there is an information component generally referred to as "the message." The message may be an object of interest in the evaluation of health education when one questions the necessity of specific knowledge or information in order to take specific health actions.

Information is seldom neutral. In presenting information in the form of a message, one generally presents it in a context, in a style, or in a tone that constitutes an appeal to specific motives that the receiver of the message may have. The appeal to these motives constitutes a strategy that is essentially either informational, normative, or emotional. The strategy selected, as with the message and media selected, all depend on the specific target group in question and the specific actions or behavioral problems in question. They also depend on the program context in which they are employed. But in any case, the strategy or appeal may itself constitute an object of interest for purposes of evaluation. The strategy should not determine the selection of a problem, but the problem should determine the selection of strategies. It is for that reason that I have worked backwards in the causal chain in discussing different objects of interest for evaluation.

Each of these objects of interest has associated with it certain desirable results defined by its place in the causal chain. The question of results can be discussed in relation to the term comparison in the

definition of evaluation. The notion of desired result has to do with standards of acceptability and will be discussed in that context in the following section.

Measures of Comparison: Methodological Issues

Without comparison, there can be no evaluation. In order to compare, one must have some form of measurement--either qualitative or quantitative--that enables one to describe in concrete terms the object of interest. Working back again in the causal chain, the health problem as an object of interest has certain measures that can be used to compare the health problem as evidenced in one person with the health problem as evidenced in another person, on one group in comparison with another group, in a person in comparison with the same person at another point in time and so forth. These measures include vital indices of mortality, morbidity, disability and the like. For groups, these measures may be expressed in terms of incidence, prevalence, distribution or extensity; and for individuals in terms of intensity, duration, frequency, time of onset, and other diagnostic dimensions.

The measures available or capable of being produced in relation to behavioral problems include utilization and compliance indices from medical records, clinic or hospital billing records, direct observation and surveys in which people are asked about their own behavior or the behavior of others whom they have observed. The dimensions of behavioral measurement that are relevant to health include earliness, frequency, range, persistence, and quality.2/ Some behavioral problems, for example, may be defined primarily in terms of earliness in the sense that the behavior must be taken early in relation to the onset of the condition in order to be effective. Other behaviors may be important in terms of the earliness with which they are taken in relation to age, duration of marriage, or exposure to risk.

The dimension of frequency for the measurement or comparison of behavior is important when the behavior is or should be repeated on some kind of schedule. In the case of negative behavior, it may be more or less damaging depending on the degree to which it is done more or less frequently.

The quality of behavior is a dimension that may be used as a measure for comparison when the behavioral problem in question is one in which there is a choice between two or more courses of action, one of which is more damaging to health. The proportion of a population choosing, or the

2/ These dimensions are described in greater detail in Green, L.W., Status Identity and Preventive Health Behavior. (Berkeley: University of California Press, 1970), pp. 6-8.

tendency of an individual to choose the more appropriate behavior is a measure of the quality of health action. For example, when an individual has the choice of sources of medical care and chooses chiropractors over medical practitioners, he has made an inappropriate choice and would not compare favorably on the quality dimension. It is possible with some health problems to have a variety of choices which can be ranked in order of their appropriateness to the solution of the health problem. In such cases one has an ordinal index of quality of health behavior.

Range refers to the variety of different types of health actions required in relation to specific health problems. In relation to diabetes, for example, the appropriate behavioral response includes diet, exercise, medication, foot care, and skin care.

A final dimension of health behavior is that of persistence. As a comparison measure, persistence is concerned with the degree to which a health action is continued over time, such as continuation of a medical regimen ("compliance") or the continued use of contraceptives (IUD "retention" rate) in the case of family planning.

These then are measures of behavior as the object of interest that provide for comparison of one behavior with another in the same individual or group, different behaviors between individuals, or actions at different times by the same individual or group.

Continuing back in the causal chain to the next set of objects of interest, each of the various factors contributing to the behavioral problem has various measurement possibilities for comparison purposes. The enabling factors, for example, can be compared on dimensions of availability and accessibility of resources. Such measures may be obtained through community agency surveys, inventories of available resources, geographical analyses of service locations, ratios of physicians and other health personnel to population, and the kinds of compilations of data on service facilities published routinely by the American Hospital Association, Comprehensive Health Planning and Regional Medical Planning Agencies.

The predisposing factors are generally measured through the use of questionnaires and interviews to ascertain knowledge, attitudes, beliefs, values, and perception related to health behavior. These data are collected most efficiently through sample surveys and ideally employ standarized instruments to maximize the comparison potential.

The reinforcing factors can be measured through the same kinds of instruments as the predisposing factors, but to the extent that the reinforcing factors involve staff behavior or the behavior of health personnel, they may also be measured through rating forms completed by supervisors, trainers, and consultants. These ratings can then be compared against some standard of acceptability to be discussed later. Another

useful measure for comparison in relation to reinforcing factors is participant observation. This requires the rater to be at least a temporary member of the staff in which the ratings are to be made.

We come now to the total program which may be an object of interest for certain evaluative purposes. Measures for comparison in this case usually consist of a combination of the foregoing measures, but may also include evaluative measures in relation to the planning process and the structure of the program. Suggested criteria for comparing the appropriateness of various steps in the planning process are available from educational and administrative theory. Each of these criteria could then be rated or measured on a scale according to the degree to which the program planners adhered to that principle of planning. Similar criteria and rating scales can be suggested for the problem diagnosis stage, the preparation stage, and the implementation stage of program development. Professor Marjorie Young of the Harvard School of Public Health and I have developed a set of forty-three such criteria and rating scales and pretested them with Macro-Systems, Inc. on 13 drug abuse education programs in the Eastern states. I have since had students and colleagues apply these rating scales to an additional 50 or so programs for which they have had responsibility or major involvement and the general feedback has been that the criteria and rating scales are particularly helpful in identifying weak points in the program development process. The criteria and rating scales are particularly applicable to health education programs, but also appear to be applicable to other components of health programs as well as other social service programs.

Another approach to measures of comparison for programs as a whole is the social experiment approach, or more properly, social quasi-experiment in which the program is directed at a subpopulation and the results compared with those in another subpopulation that does not receive the program. This method of comparison essentially involves comparison of the program with a situation in which no program is conducted. Variations on this approach allow for comparison with situations in which modified versions of the program are conducted.

I would like to propose as a general principle of evaluation that in assessing the utility, effectiveness, or efficiency of specific educational techniques and methods, that the total program be established and operational before the specific technique or method that is the object of interest is evaluated. This would be done then by withdrawing that technique or method from selected (randomly identified) sub-groups within the population receiving the total program. This approach is fundamentally at variance with the usual approach to evaluating health education techniques and methods in that it treats them within the total context of the program rather than setting up a program that revolves around the specific method or technique. Thus, when a panphlet is the object of interest, it seems to me inappropriate to evaluate the effectiveness or utility of a pamphlet

by setting up a program that consists of virtually nothing other than the pamphlet. The pamphlet can more appropriately be evaluated within the context of the program in which it might be used. That would require introducing the pamphlet from subgroups within the program.

When social psychologists set out to evaluate specific appeals as the object of interest (for example, comparing fear arousal with informational appeals), they frequently do so in a laboratory or other highly controlled situation in which the message is the total program. I doubt the utility of such evaluations and suspect that they have limited generalizability to the community settings in which programs are conducted.

One of the most distressing results of this approach to evaluating health education techniques and methods is that the results are more negative than they should be. When a social psychologist attempts to change a health belief in a laboratory situation using nothing more than a film or a written message or other communication device and finds on follow-up that the belief has not changed, he then calls into question the utility of health education in general. The readers of such reports frequently cite such studies as evidence of the limited efficacy of health education programs. I would argue that such studies in no way call into question the utility of health education, because the objects of interest, i.e., the independent variables in such studies, are not to be confused with health education. They are nothing more than specific media, messages, or appeals that may be used as aids in health education programs. Thus, the error is both methodological and conceptual.

The above examples are specific cases of the more general problem in the literature of sophisticated evaluative studies having been done on trivial health education programs. The total impact of reading the literature, which is replete with such studies, is a negative picture for health education in terms of effectiveness and cost-effectiveness in particular. I strongly urge health educators to resist the pressure to evaluate before they have sufficiently developed their programs to make them worthy of evaluation and to make the results more predictably positive. There is no point, it seems to me, in making large expenditures on evaluation of half-baked programs unless such programs are typical of all programs in which large amounts of money are being expended and the purpose of the evaluation is to bring an end to such expenditures. I do not think that that situation fairly characterizes the majority of serious health education programs, and I therefore urge that as much attention be given to the quality of the program as to the quality of the evaluative research methodology.

Standards of Acceptability

In discussing the objectives of health education programs earlier, we used the term "desired results." We have discussed the various methods of comparison for measuring results. Now we must fact the more difficult problem of how to measure what is desirable. In reviewing the literature, I have tried to classify studies according to the implicit standard of acceptability that is used when comparisons are made, as they inevitably must be in order for the study in question to be truly classified as an evaluative study. The usual standard of acceptability is a comparable situation in which the object of interest is different in some sense.

The most frequent dimension for comparison is the time comparison, and I refer therefore to historical standards of acceptability as a major class of standards used in evaluations. These are the standards, implicit or explicit, that are used when the comparison is between different points in time for the individual, the population, the problem, the program, or the technique that represents the object of interest. It is the standard employed, for example, when one asks the question, "How does our program this month compare with last month?" "How is the program progressing compared with last year?" It is the standard employed when one plots trend charts with units of time on the abcissa ("X" axis). The "Y" axis may be the number of persons visiting the clinic, percentage of positive responses on a survey instrument, or other dependent variables, but the comparison is between different points in time.3/

A second standard of acceptability frequently used in evaluation is the normative standard. This is the standard implied when the evaluation asks the question, "How does this program compare with others?" "How does our program compare with the national average?" Regional comparisons are used quite frequently as the norm and it is usually wiser to take comparable programs within the same region to eliminate the influence of extraneous variables. Thus, it is more reasonable to compare patient education programs in similar types of hospitals than to compare similar programs in entirely different settings. The norm selected for comparison can make the difference between judging a program a success or failure. This is true, of course, for all of the standards of acceptability.

3/ Deniston and Rosenstock have recently reported on the limitations of evaluations that depend on time comparisons. O.L. Deniston and I.M. Rosenstock, "The Validity of Nonexperimental Designs for Evaluating Health Services," Health Services Reports 88:153-164, February 1973.

The extreme case of this problem is represented by the third standard of acceptability, the absolute standard. When program administrators or policy boards set 100% solution of a problem as a goal, then the object of interest may have to be compared against that standard regardless of how realistic it may or may not be.

A fourth standard of acceptability is the theoretical standard which is based on theory and previous research and it says in effect, this is what we would expect to achieve if everything went right in the program. Theoretical standards are sometimes referred to as professional standards or scientific standards.

A fifth standard of acceptability sometimes set for an object of interest is an arbitrary standard. This type of standard is simply the opposite from the theoretical standard in that it is usually based on a complete lack of information rather than a thorough analysis of information. It may be set by an administrator in the absence of consultation or previous experience with the problem, or it may be set for purposes of providing the staff with a target and setting quotas for staff performance, even though it is not known whether the staff can be expected to achieve those quotas.

A sixth type of standard is the negotiated standard, which is usually somewhere between the theoretical standard and the absolute standard. If a consumer group or a political action group has set an absolute standard, an administrator has set an arbitrary standard, and a consultant or funding agency has set a theoretical standard for a program, there may follow a process of compromise in which an intermediate standard is negotiated. This then becomes the goal for the object of interest and is a standard of acceptability against which the object is compared.

The present state of the art in patient education and many other areas of health education leaves us most frequently with historical and normative standards and, in the case of new program areas, often with arbitrary and absolute standards. As we accumulate a body of literature, we should begin to formulate theoretical standards that can be employed in the evaluation of health education programs.

PLANNING FOR PATIENT EDUCATION: CONSIDERATIONS AND IMPLICATIONS

*Elizabeth A. Lee, R.N., M.S.N.**

My suggestions to you evolve from a project that is concerned with the education of adults with a chronic disease. The principles can, however, be applied to most patient education situations.

Three concepts are basic to the understanding of the planning of an educational program for an adult with a chronic disease.

A. An organized patient education program for the adult with a chronic disease should evolve from the health care system. The person with a chronic disease first learns about his health problem within a health care agency. Though there are other ways for him to learn about his health care, his time in contact with the system should be utilized to help fulfill his education needs. It is also the responsibility of health professionals to assure that the patient receives the necessary education and support to carry out his therapy safely. For these reasons, an organized education program should evolve and be guided from sources within the health care system.

B. The goal of a patient education program should be to enable the chronic disease patient to function as independently as possible. The educational program must help the patient and his family integrate necessary therapy into the pattern of daily living. If this is not done, the patient will not carry out the necessary health care actions. He also may rely on sources other than himself to carry out functions which he can perform or has the potential to perform himself.

C. An efficient organized patient education program for the chronic disease patient must be planned regionally. Because the chronic disease patient can receive information in many health settings and because the

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length of time spent in each setting as well as the amount of information which can be absorbed in a certain time frame varies, planning must be on an areawide basis.

In addition to hospitals, examples of the kinds of settings and agencies that should be incorporated in an areawide plan include: physicians' offices, outpatient departments, neighborhood clinics, prepaid group practices, industries, schools, nursing homes, custodial care homes, Visiting Nurses Association, Public Health Departments, Ostomy Association, Diabetics Association, Heart Association, Kidney Foundation, Lung Association, and Cancer Society.

The result of an areawide plan should be:

1. Consistency of information.
2. Maximization of the utilization of potential education time.
3. Ability for reinforcement and follow-up.

Planning for an organized patient education program must include a survey of the elements that comprise a patient education program. The elements are patients, staff, materials, and settings. These elements are interrelated and will affect each other as well as the total program of education. An approach to the study of these elements and the effects of each on patient education are outlined in the following paragraphs.

PATIENT

In order to determine educational needs of a patient, one must first look at the demands that are placed on the patient because of his health problem(s) and because of therapy that is necessary because of the health problem(s). Then it must be determined what he knows about these demands and his ability to carry them out. The relationship between the above will determine the type and amount of assistance the patient needs. Demands plus patient ability equals assistance needed.

Areas of educational demands for the adult with a chronic disease include the following:

health problem(s)	activity
diet	preventive measures
medication	community resources

UTILIZATION OF HEALTH FACILITIES

Depending on the necessary therapy associated with each of the above areas, the patient will have to accomplish a, b or c.

a. learn information (example: What is diabetes?)
b. learn information and perform a new behavior (example: giving injection)
c. learn information + change a previous behavior (habit) + perform a new behavior (example: reducing diet)

Knowledge of which of the above are involved will help determine which staff, how much time, and the educational methods that should be used.

Assessment of specific abilities will help determine the degree of assistance that will be needed and will also help shape the education plan. Not every patient needs, wants or can comprehend the same amount of information. The language needed to communicate to patients may also differ. In order for general content material to be made specific to a patient or population, information about the patient's or population's health beliefs, information about attitudes that may affect response to care either favorably or unfavorably and information concerning misconceptions must be determined. Reading ability, writing ability, hearing, vision, comprehension, attention span, memory, mobility, and coordination must also be assessed. Patient interviews should be used to help make these determinations.

A professional person should initially assess the patient's ability to meet the educational demands placed upon him and be involved in the establishment of goals and setting priority of goals. When setting the priority of goals he should be guided by:

1. The importance of carrying out an aspect of therapy.
2. The degree of difficulty the patient or population will have integrating the activity or activities into the pattern of daily living.

Difficulty in terms of both physiological and psychological abilities needed depends upon whether it's necessary for the patient to learn information, learn a task, or change a habit--the latter being the most difficult.

STAFF

Though patient education is presently being promoted as an activity by professionals, patients, and administrators alike, it nevertheless represents an innovation as an organized program. It has been recommended

that a person be designated to assume the responsibility for the development of an organized program within health care settings. Such a person who could be shared by several health settings, could be the director of health education for a specific setting, or could be the education specialist for the specific programs within the health setting. The person could be a member of any of the health care professions as long as they have an educational background. The person's responsibility would include guiding the education program through the appropriate channels and teaching health workers knowledge and skills involved in patient education.

Presently there is a lack of clear allocation of responsibility among health personnel concerning patient education. Physicians play a major role in initial information giving. However, the continuing education and support needed to learn tasks and adapt to change should primarily be the responsibility of others on the health team.

Each patient's educational needs should initially be assessed by a professional person. A person should also be responsible for seeing that the educational program is carried out. The nurse is the member of the health care team who is found in most health care settings. She should have the educational background to assess patient needs, help set educational priorities, and coordinate the teaching program. The amount of education the nurse carries out on her own varies with the number of other members of the health team she has available, i.e., dietitian, pharmacist, social worker, etc.

Nonprofessionals, including volunteers, can help with the educational program. In some already established programs, persons representative of the patient population have been trained as health counselors. All nonprofessionals should have professional supervision available.

All contacts with patients should be viewed as a potential time for information gathering, information giving, and reinforcement. Thus, all personnel who come into contact with patients should have the basic knowledge and skills involved in patient education.

The knowledge and skills of supervisory personnel should enable them to identify the educational needs of patients and families, to establish educational goals and objectives, to select appropriate educational methods, and to evaluate the educational program.

SETTINGS

Settings are made up of the space and time in which patients encounter health care personnel. As far as space is concerned the physical location of a patient classifies him as either an inpatient or outpatient:

inpatient	outpatient
a. Patients are on same floor vs. different floors	a. Patients come by appointment
b. Patients are mobile vs. bed-ridden	b. Patients come to "specialty" clinics
c. Private room vs. wards	c. Patients are in the home
d. With or without family visitors	

The major effect of the physical location or space factor on the delivery of patient education is the determination of whether group or individual teaching takes place.

As far as time is concerned, the quality and amount of teaching is obviously related to the amount of staff time committed to the program. In addition, the patient's time in contact with health care personnel varies in these ways according to whether he is an inpatient or outpatient:

inpatient	outpatient
1) Average stay also minimum and maximum stay	1) Average number of total visits
2) Time available for education (consciousness, degree of illness)	2) Length of visits
	3) Frequency of visits

Therefore, initially, the opportunities for educating the patient or patient population should be determined by tracing the patient flow pattern through the health system both within and outside the hospital. Information gained from documenting the patient flow pattern should include the following:

1. Where patients come into contact with health personnel.
2. The personnel who come into contact with the patients.
3. Amount of waiting time involved.
4. Approximate number of patients in one place at one time.

MATERIAL

Educational materials selected should be those that are the most efficient use of manpower, time, materials, and monies which will effectively meet the needs of the specific population.

Materials consist of the media used by staff to communicate with staff and media used by staff to communicate with patients.

Facilitation of communication between the members of the health care team is affected by the staff's utilization of such tools as:

patient history	problem-oriented record
team conference	nursing care plan
nursing conference	patient's chart

The overall plan for a patient's education program emanates from utilization of these tools. A failure to utilize these tools, on the other hand, results in breakdown of communications and subsequent poor assessment of the patient's learning needs.

Staff communicates with patients directly (person-to-person contact) or indirectly (person-to-media-to-person). For each of the educative demand categories, there is general information that is needed before the information can be made specific to the patient. The general information can be given to the patient by means of indirect communication. A person-to-person approach (direct communication) is needed to adapt the general information to the patient's needs and abilities, and to respond to the patient's specific questions.

The most efficient patient education program utilizes both the direct and the indirect methods of communicating with patients. If there is too much indirect communication, the specific information is never relayed to the patient. If there is too much direct communication, staff time is not efficiently utilized.

Group classes have proven an effective and efficient way to carry out patient education. If a series of group classes are held to give information, both about a task and to give patients a chance to express concerns and ask questions, the members of the group need not be the same. However, if the purpose for having the group is to use the group to help change a habit (e.g., diet or smoking) members of the group must be the same.

Take-home material for the patient should consist of a step-by-step explanation of any tasks he is to perform, medication information, any side effects the physician should know about, and a name and phone number to call if he has problems with his therapy.

EXTERNAL FACTORS

Health workers must also be able to assess external factors which might interfere with the patients' participation in his treatment program and thus the educational program. Some of these might include:

Transportation.

Cost.

Time of clinic.

Length of clinic visit.

Not able to be free of various obligations including job, household, social, and child care.

Poor relationship with health personnel, i.e., different health providers with each patient visit, and/or negative attitude of staff toward patients.

GENUINE COMMUNICATION: A KEY TO EFFECTIVE TREATMENTS

*Bertram W. Pepper, M.D.**

To establish effective verbal communication with another individual it is essential that there be a willingness to first remove whatever blinders or preconceived ideas may exist concerning the other individual.

Eye contact is a powerful tool which cannot be too strongly emphasized. Let the other person know that you're interested in his welfare and you are responding to whatever messages he is trying to send to you.

Organize your information in such a fashion that it is easily understood and is useful to the patient. Don't burden him with more facts than he can absorb and apply. To be most effective, leave him only three major points to remember and put to use.

The senior staffs of health care facilities should carry their responsibilities in a fashion whereby they will continue to be warm human beings able to communicate with their patients. It should become their responsibility to set an example for new employees and help relieve them of whatever anxieties they may bring to the job. Too many health care facilities give prime consideration to the welfare and comfort of the staff, forgetting that the patient should be the center of attention.

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Highlights from...

METHODS FOR PATIENT EDUCATION

*Anna W. Skiff, M.P.H.**

SOME OBSERVATIONS ABOUT TEACHING

Before good teaching can occur, there must be a commitment to the importance of teaching. A quotation of the philosopher, Alfred Worth Whitehead, is applicable to the obligation to teach patients: "Where attainable knowledge could have changed the issue, ignorance has the guilt of vice."

Patient teaching must be intentional and planned. It is not just a new technique grafted on--like learning to work a new machine. It is a transaction based upon respect for the individual and confidence in his capacity to be active on his own behalf. For many health workers it presents a whole new way of relating to patients. A change from "doing to--to doing with."

Count on investing a sizeable block of time in planning an educational activity--especially in early attempts to develop programs.

COMMENTS ABOUT METHODS IN GENERAL AND FACTORS INFLUENCING THEIR SELECTION

Methods are a broad approach to instruction as contrasted with teaching tools and techniques which are "buttons on a coat" once the method is decided upon. Methods are "a planned set of procedures whose goal is to produce a desired learning outcome."

A prime factor influencing the choice of a method is the nature of the goal or outcome to be attained. Is the goal to acquire new knowledge? To be able to perform a new skill? To accept a new way of life? Different outcomes will require different methods.

Characteristics of the learner influence the choice of a method. In addition to considering cultural practices, educational level, and past experiences of the learner, his physical state in the medical care setting shapes what can be done. Frequently, the patient-learner doesn't feel too well; he is truly uncomfortable and finds it hard to give attention to other than direct care services.

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People have different learning patterns. Some approach learning situations with great excitement, some with caution, some reject the idea. People vary in their need for theoretical background.

The hospital's physical and psychological environment affects the choice of methods. There are few places--except in newer institutions--where systematic teaching can be carried out. There is little privacy. Treatment services (doing to people) have first call on patient and staff time. It is a challenge, someone has said, to find ways "to provide orderly learning in a disorderly setting."

Other important considerations in the choice of method are the time available for teaching, the costs involved and, not to be overlooked, the personality and preparation of the teacher. What method is the teacher comfortable with, what is he prepared to do?

"The best methods are vivid. They involve the learner in doing something, observing, participating, discussing." (This statement points up the change the use of the educational method represents for the health field and health workers. The patient-learner must be active--not passive).

A major challenge in the use of <u>any</u> method is to find ways of building it into the patient's program within the setting. When will it be introduced? Who will take responsibility for carrying it out?

AN OVERVIEW OF SPECIFIC METHODS

The Tutorial Method--the one-to-one teaching--is the strongest, the most successful, and the most expensive instruction method. It requires planning and preparation to be effective. It is versatile and can accommodate to the learner's needs.

Coaching is a method in which the person learns by emulating and identifying with the person who has a message to bring. Members of self-help groups, persons who have had mastectomies, ileostomies, or amputations frequently help carry out this method. They bring information and provide a model for building a new life style. Their contribution needs to be carefully utilized in the teaching program.

The demonstration method is useful in assisting someone to learn a new skill or carry out a new procedure. The person is shown what needs to be done; he practices the activity; he is evaluated and assisted to improve his performance. Although this method is costly in personnel, there are some learning tasks for which there is no acceptable substitute. The instructor must carry out the demonstration properly; he must allow time for the individual to practice and improve his skill.

Programmed instruction, as a special form of self instruction, presented in programmed books and teaching machines and video tapes offers information in small steps. The learner can go at his own pace; there is immediate feedback for him on his progress thru the experience. At the

present time, good programs are hard to find, and it is time-consuming and requires special training to prepare them. This instruction method, as others, must be incorporated in the patient's care plan and its usefulness to the patient should be ascertained.

The method offers a way of presenting basic information about a condition to patients when the content is well agreed upon.

Work With Groups of Patients

Guided group discussion, with staff assuming a strong leadership role, is employed to acquaint groups of patients with similar health problems with what they need to know and do. The size of the group must be limited because it is difficult to involve more than 15 people effectively in discussion.

This method is economical of staff time; for example, one staff member meets with a number of persons to explain low sodium diet requirements and to assist them to understand the properties of different foodstuffs. Limitations of the method are: individual differences cannot be accommodated, sessions need scheduling, patients need to be invited and transported to the session, and a place for teaching must be arranged. The major advantage of group discussion is that a wider range of questions may emerge and all members of the group have the advantage of hearing all the answers. Someone has said that "good questions are the lifeline of effective guided discussion."

Group sessions whose goals are to mobilize the strengths of group membership and association for standard setting or to achieve behavior change, must provide the members with time and the opportunity to become acquainted and trustful of one another. A collection of strangers who are brought together for one session or at widely spaced intervals cannot achieve these goals. The groups need to meet frequently and to set their own goals. Staff needs to be prepared to work with these groups and to be familiar with and able to assist with interpersonal issues that may arise.

The lecture method is flexible, widely accepted, and can be used with large groups as well as with smaller groups. It cannot accommodate to individual needs and little feedback is available; the method is most effectively used in the presentation of information or introduction of new ideas. It is rarely used for teaching patients in the medical care setting.

Combinations of methods can be used and the strengths of each exploited to achieve different goals. For instance, a patient may be given self instructional material to enhance his knowledge of his heart problem and a demonstration of how to take his pulse or how to schedule his medications accurately.

ABOUT MATERIALS

Many pamphlets, filmstrips, and slides are available from governmental, voluntary, and commercial sources to contribute to the teaching program. Some materials, particularly instructions specific to the setting, must be prepared by the teachers themselves. These materials need to be thoughtfully employed as an integral part of the program. They are tools to reinforce, make more vivid, and explain. They need to be reviewed for technical correctness and for acceptability to the learners' needs and ability. Proceed cautiously with investments in "hardware" such as projectors, audio-cassettes, videotapes, and teaching machines. Before purchasing, examine their flexibility and versatility.

REFERENCES AND SUGGESTED READING

1. Principles and Techniques of Instruction

Extension Course Institute of the U.S. Army Air Force, Maxwell Air Force Base, Alabama, 1966, was drawn upon heavily in the preparation of these remarks.

2. Nursing Clinics of North America, December, 1971, Teaching Patients has useful material as do other volumes of the series.

Excerpts from...

Reactor Panel

PHYSICIAN: Dr. Jack J. Rheingold, Senior Attending Staff, Washington Hospital Center, Washington, D.C.:

Although many physicians are connected with medical schools, there are few who are teachers. Efforts in this area can be extremely rewarding. It is helpful to both the physician and patient if the patient has pertinent information concerning his illness. Hospitals should make every effort not to depersonalize its patients. The physician plays an important role in making the patient feel he is an individual. Whenever possible the physician should instruct the patient on how to follow-thru on his self-care.

HEALTH EDUCATOR: William A. Fackler, M.A., Director, Department of Health Education, Albert Einstein Medical Center, Philadelphia, Pennsylvania:

Health educators must establish priorities and the ambulatory patient must be placed high on the list. . . . The task of health education covers such a broad base that the health educator finds if he is to accomplish his goals he must reach out for assistance from a variety of sources (e.g., other health professionals, volunteers looking for meaningful experience, patients, closed circuit television hooked up in the patient's room).

NURSE: Shirley Sohmer, R.N., Head Nurse, Department of Neurology, Johns Hopkins Hospital, Baltimore, Maryland:

It is essential that the educational program be focused on both the patient and his family. . . . Other disciplines should be called in, as necessary. Patient education can be interwoven in the daily care given him. We should not expect a patient to become educated merely by telling him what to do. He must learn how to follow through on those things he is being taught. The patient has a right and a need to know certain pertinent facts about his illness and the role he must play to hasten his recovery. Prior to discharge, bring in the nutritionist and other appropriate staff to advise the patient concerning the regimen he must follow and patient clinics suitable for him to attend.

NUTRITIONIST: Clare E. Forbes, R.D., M.P.H., Chief, Division of Nutrition, Maryland State Department of Health and Mental Hygiene, Baltimore, Maryland:

Every effort must be made to make the patient aware that ultimately he is responsible for his own health. The patient is more apt to accept this responsibility if he is involved in planning the regimen he is to follow. Evaluation must be incorporated in the patient education plan.

PHARMACIST: Peter Lamy, Ph.D., School of Pharmacy, University of Maryland, Baltimore, Maryland:

The pharmacist has an important role in instructing the patient--in simple terms--on how to take his medication. . . . Far too often the patient is left with incomplete information at the time he receives his prescription. Patient education should begin at the time of admission and not when the patient is ready to be discharged. . . . Whenever possible, the interdisciplinary approach should be used.

Panel:

PATIENT EDUCATION - COST EFFECTIVENESS

*Clarence C. Pearson, M.P.H.**

The President's Committee on Health Education was created by President Nixon on September 14, 1971 to recommend ways to develop, in the general public, a sense of health consumer citizenship. This concept involves helping every American to learn how best to achieve and maintain a reasonable level of health.

To do this job, the Committee and its Staff Council embarked upon a four-phase program including (1) fact finding, (2) analysis and evaluation, (3) recommendations, and (4) devising a strategy to help implement its recommendations. In its report to the President, the Committee placed emphasis on the health care delivery system and health education findings. It stated that the Nation appears to be on the eve of major new legislation covering the delivery and financing of health care. With or without a Federal program of protection, health education should be interwoven into the very fabric of health care.

The Committee heard from many people that providing health education would be largely futile unless at the same time the health care system is modified to permit easier access. Conversely, however, providing health care would be largely futile unless at the same time health education is provided on a nationwide basis.

At the present time, health education is hardly a brushstroke on the total picture of health care and the health care industry. Of $75 billion spent last year for medical, hospital,and health care--more than $200 million a day--about 92 percent is spent for treatment after illness occurs. Of the rest, more than half is spent for biomedical research. Prevention of illness and programs of health education split the balance, with health education getting the short end.

Federal and State government commitment to health education is hardly visible. Of $18.2 billion allocated in 1973 for medical and health activities in the Department of Health, Education, and Welfare, only $30 million

*Director, Administration and Planning, Health and Welfare Division, Metropolitan Life, Washington, D.C.

is spent for specific programs in health education; and $14 million more for general programs. That amounts to less than one-fourth of one percent for health education.

Of an additional $7.3 billion allocated for health purposes of all other Federal agencies, even a smaller fraction is spent for health education.

On a State and Territorial level, health departments spend less than one-half of one percent of their budgets for health education.

Legislation exists which actually impedes the development of effective school health programs. Some of the laws on the books regarding what can be taught have not been changed since the late 1800s. In other States, needed legislation is lacking.

Attitude surveys reveal that most Americans are less informed than they realize about health matters. The vast majority--88 percent in one study--say they look to their physicians or to television commercials for information about health. However, testimony and other information indicate that most physicians are too busy to do an effective job of health education, and television commercials are more concerned with product promotion than with true consumer health education.

In light of these findings, the Committee made the following recommendations:

.That the government, prepayment plans, and insurance companies which pay for health care services for others be willing to adjust premium rates to include in their payments the cost of health education for the patients involved.

.That the Nation's hospitals be strongly encouraged to offer health education programs to patients and families--both on an inpatient and outpatient basis. Similarly, that more extensive health education--focused on the needs of the patient--be provided by physicians and allied professionals in their personal contacts with patients. The lack of health educational programs in hospitals and physicians' offices is tragically prominent at the present time.

.That a major educational program be undertaken among medical and health professionals and administrators to prepare them psychologically and professionally to accept and respond creatively to increasingly expressed concerns for consumer participation in the design of health education programs and even of health care facilities.

.That skill in providing health education be an essential part in the training and continuing education of all health workers.

.That systematic research and evaluation be a part of all education programs within the health care delivery system.

.That various health educational approaches among patients be tested to determine the ones which appear to bring about the best results in patient improvement and in reduction of need for health services.

.That health educators work with consumers, the community, health care administrators, and planning agencies to help determine the location of new health care facilities, schedule service hours, and develop procedures for use of services that will reflect the health care needs and living conditions of the people to be served.

There are a number of options regarding the financing of patient care programs, and I am quite optimistic that many of the problems associated with financing organized activities with regard to patient education programs will be resolved during the coming year. Areas in which much more information is necessary before a suitable program can be developed include:

1. Staff organization for various sizes of hospitals and medical care settings.
2. Data on current and projected costs of programs.
3. Some demonstrated evidence of effectiveness.
4. Identification of some of the major failures and successes of programs.
5. How specifically should the programs be financed--included as special item on patient's bill?

All the above need special efforts and the insurance industry is taking a very hard look at the possibilities. The concept of patient education will receive the very positive endorsement from the industry. Major hurdles will involve the specific ways in which the financial aspects can be implemented.

Remarks by

*Michael J. Brown**

The Blue Cross Association on behalf of the various Blue Cross Plans throughout the country, is currently considering the whole subject of patient education and the reimbursement aspects thereof, both for Medicare and Blue Cross reimbursement purposes. As our position is still under consideration, I am not authorized to speak on behalf of the Association and, therefore, any remarks that I make have to be regarded as my own personal opinion.

I have not had the opportunity of attending the various speeches and seminars that have preceeded this discussion during the last few days. However, I am going to propose a possible model and use that as a basis for discussion of this subject.

As a formal discipline, patient education is a relatively new aspect of health care. To some extent, it has always been present in so far as the nurse or the doctor, in the course of normal patient contact, would explain certain aspects of the patient's illness or the implications of drugs to be administered. However, this was not done on a formalized basis or as part of a larger overall plan.

The model that I am proposing would be more suitable for a reasonably large hospital, could be adapted with modifications to smaller hospitals. The basic approach has got to be multidisciplinary and it would seem desirable to have a small controlling department which would function both as an educational medium for the staff who would be involved in administering patient education, and as a coordinating agent for the various disciplines involved. Thus, it would be entirely feasible for a nutritionist, a physical therapist, several nurses, as well as various doctors involved and possibly other representatives of different disciplines to form a team that would educate patients with regard to their illnesses and to the various ways that they can be cured and future recurrence prevented.

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*Senior Manager, Plan Reimbursement Settlement Activities, Blue Cross Association, Chicago, Illinois.

To be effective, this education, in conjunction with discharge planning, must start as soon as the patient is admitted to the hospital and continue throughout his stay, rather than immediately prior to discharge. Additional factors to be considered are that the program has to be tailored to the patient as an individual and so must deal with his own personal requirements, and must take into account the environment to which he is going to return.

Patient education differs from general health education for the community as a whole. Patient education is strictly individually oriented and takes into account the requirements of the patient, whereas community health education is mainly preventative and usually consists in media advertising, brochures, group instructional talks, and possibly clinics, and usually refers to one specific broad area of health care. For example, annual physicals, cancer prevention, or tuberculosis.

Turning to the cost implications, it is extremely difficult to measure the effectiveness of a patient education program. Possible measures of effectiveness might be a reduction in the overall length of stay per patient, or a decline in the proportion of patients who were readmitted.

However, the quality of care aspect is impossible to measure and the actual impact on costs is also extremely hard to measure. As this is a new field, there is presumably no data available as to the cost effectiveness of patient education, and, indeed, one wonders on what basis the data would be gathered and what statistics would be needed to provide a base to evaluate this program.

Standards to be used against which to measure the cost effectiveness must also be considered. Who is going to determine what results are expected out of the program? Is there a cheaper alternative that achieves a better or at least as good results as the proposed program? One possible means of measuring the effectiveness is to compare two similar hospitals or groups, one using patient education and one not using patient education. Assuming all other things are equal, there should be a demonstrable improvement in the group using patient education.

Mr. Pearson, in his remarks, referred to a cost of $.50 per patient day as an arbitrary figure. Obviously, this will depend upon the size of the hospital and the number of staff involved. I understand that Mr. Pearson was considering a 300-bed hospital, and so it might not be unreasonable to consider a nutritionist, a physical therapist, several nurses, and a coordinator. Assuming 80 percent occupancy, the $.50 per patient day cost works out to approximately $45,000 for one year, and this would probably only cover the direct salary costs. The indirect costs (the overhead costs) could substantially increase this figure. However, against this has got to be set very possible savings as a result of the effectiveness of the program, and some of these may indeed occur even during the patient's hospital stay. As indicated earlier, a shorter length of stay and a decline in admissions would provide a considerable overall savings. I must add a caution here, that people talk very easily about the savings that would accrue from an overall decrease of one day

in the average length of stay. In the short term, there is not likely to be a substantial savings, as most hospital costs, in the short term anyway, are relatively fixed and a reduction in patient days would actually result in an increase in at least the routine costs per patient day. However, in the long run, steps could be taken to reduce costs so that they were more in line with the actual patient load. This pre-supposes that the reduction in the overall length of stay was not compensated by increased admissions.

There are two possibilities when it comes to accounting for the cost of the department involved in patient education. The first possibility is that all of the participants, irrespective of the discipline to which they belong, participating in patient education, are administratively grouped under a patient education department, and all of the direct and indirect costs associated with patient education flow through this one department. This would also include a cost associated with training these people, and of the coordinator. The second possibility is to leave the actual operating costs within the disciplines involved and to only include in the patient education cost center, the coordination costs and any costs specifically incurred for patient education that are not specific to a particular discipline. The question has been raised as to whether it is desirable to make a separate charge for patient education. Clarence Pearson has indicated that he is in favor of such a charge, as he feels patients should be specifically billed for any services that they receive, and this is a specific service. My personal inclination is that this depends upon whether all patients in the facility are going to receive this service. For example, a terminal cancer patient, or a very brief stay, and whether it is merely available to selective patients. It would seem desirable to have it available to all patients, and so, there is a lot to be said for including the cost as part of the routine service cost. This is administratively simple and avoids any complications from patients questioning the service and complaining that they did not receive the service or any benefit therefrom.

Is this a covered cost under Medicare? Unfortunately, that is not an easy question to answer. Mr. Tierney, who is the Director of BHI, was present at a meeting on this subject on December 12, 1972, and he stated that Medicare probably pays for some patient education now because it is folded into other services, but, as an isolated new service, it would probably be denied under present rules. He offered two courses: he is confident that he can get authority to allow extensive demonstrations, or he could request the HEW Secretary to rule that patient education is allowable within the intent of the law. I understand that as a result of that conference it was decided that there had been sufficient demonstration projects and the question now arises as to what the government is going to do about it. One of the major factors influencing this decision is whether or not patient education is really a cost of providing patient care. The sort of approach that I have outlined which takes into account the needs of the individual patient, the patient's environment in the home setting and is integrated as a multidisciplinary approach right throughout the patient's stay, makes a fairly strong case that patient education of this sort is indeed related to patient care. However, the final decision on this is not mine to make.

Remarks by

*Mark Rosenberg**

Employee education has two major end results: better care and greater efficiency resulting in a more economic operation. ... Patient education could result in less time spent on patient complaints and more involvement of patients in their own care. ... Some of the resources that could be tapped in carrying out a patient education program include outside consultants and professional and licensed personnel.

After patients become better informed, they will require less staff time. The nursing staff then will be able to spend additional time with the patients who are more severely incapacitated. Moreover, the more efficient use of nursing staff time might possibly result in a reduced staffing ratio. But regardless of whether there is a reduction in staff, the better nursing care will lead to greater profits since the reputation of the home will result in a higher occupancy rate.

Nurses' aides spend much of their time with patients who want attention. Patient education will help allay much of the apprehension experienced by the patients.

In terms of costs, 2.5 hours of individualized care is provided each patient each day. Two hours are spent by aides and R.N.'s or L.P.N.'s spend the remaining 0.5 hour.

Nursing assistants can be used in the education process since, in many cases, they know the reason for such things as restricted salt diets, low sugar diets, raised head or raised feet, and nonweight bearing.

The Hospital Cost Review Commission is a new State agency established to review costs and rates of health care facilities. The Commission will also set up a uniform chart of accounts which will separate and divide costs into groups so that a better comparison can be drawn among similar types of health care facilities.

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*Director, Edgewood Nursing Home, Perring Parkway Nursing Home, and Valley View Nursing Home, Baltimore, Maryland.

A professional nurse frequently provides inservice education to the nursing staff. During the training periods patient education could be taught to the nurses and the aides. Others who could be involved in patient education include consultants, special inservice education teachers, and nursing assistants.

The question of whether an institution should budget additional funds for the purpose of patient education is still a matter for debate for nursing home boards of directors. Those opposed argue that the Medicaid rate of $18 per day is below that of the actual output by the nursing home. This, however, is an unwise course to follow since ultimately considerable savings will be realized as a result of a patient education program.

Highlights from...

PATIENT HEALTH EDUCATION – DREAM TO REALITY

*Leonard E. Albert, C.P.A., M.S.**

Health education is teaching patients to cope with health problems. The health field has not been sufficiently educated by health educators.

In trying to sell your program, you benefit yourselves and the program by health education. If health education is neglected, the patient is cheated.

Health education is a valuable resource. Somewhere in the training continuum the patient should be trained to do what he can for himself, to the extent possible.

Each of us has a dream of what we hope to achieve. Before the health educator can make his dream a reality he must sell his program to the fiscal people. You must develop your justifications on a cost-benefit basis. Legislators and boards of directors must look for ways to maintain a balanced budget. If they don't understand the need for a program and there is little public demand, that program will go. It therefore becomes incumbent upon the health educator to do an effective "selling" job.

How successful is your program? Find a "key" and push it for all its worth. Sell two good ideas and you'll get support for other ideas. You must justify your program to the fiscal mind.

There are three stages in achieving one's objectives: first, getting on; second, getting honor; and third, getting honorable.

To sell your program, you must show the administration that ultimately it will save money for the institution.

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*Director of Administration, Maryland State Department of Health and Mental Hygiene, Baltimore, Maryland.

WHO KNOWS

*Harald M. Graning, M.D.**

As a prologue to my comments I would like to state that although Americans have a right to good medical care, they do not have a right to good health. Good health is not a right but a shared responsibility. The patient has the prime responsibility for concerning himself with those measures which lead to good health.

Do you think that you are able to recognize the occasions when you behave as a parent, as an adult, and as a child? Most of us will say we do. It is far more likely that we can recognize the different kinds of behavior more clearly in other people than in ourselves.

Do you recognize that during an acute disabling illness, patients are prone to behave as children, but during a chronic illness they are more apt to behave as adults or as parents? And do you recognize that patients who behave like parents cannot be taught while they are behaving as parents? Are you aware that health professionals, who behave as parents are irritated by patients who behave as adults?

The subject of my address is "Who Knows?" I would like to talk to you about "who knows" in terms of several things. Many times we are inclined to think that as health professionals we know best. And it is because we think we know best that when we behave as parents we find we are irritated by patients who behave as adults.

Do you recognize that patients who behave as adults are irritated by health professionals who behave as parents? And are you willing to have a patient functioning as an adult question the suitability of the treatment regimen and the information that has been provided? Are you willing to let patients do comparative shopping? We find it perfectly acceptable when a person plans to buy a car to go out and do some comparative shopping. In fact, he would be ill advised not to do this.

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*Assistant Surgeon General, Director, Health Care Facilities Service, Health Resources Administration, Public Health Service, U.S. Department of Health, Education, and Welfare, Rockville, Maryland.

In the case of a patient who is acutely ill, it is readily understandable why he would accept anything that the health professional tells him. But when we're dealing with the chronically ill--and these patients far outnumber the acutely ill--it is not surprising that as an adult they might want to question the health professional. We have far too little opportunity in our present day health system for people to question the reliability of the information given to them or the appropriateness of the information of the person who is providing it. Therefore, because we have been trained as health professionals to function as parents do in terms of giving advice, we become irritated when people do not behave as children but as adults and ask many relevant questions.

The ideal situation is when the patient acts as an adult and asks pertinent questions. The health professional, rather than become paternalistic, should respond as an adult and provide the patient with information he should have.

Who knows what the patient wants to understand? Who knows what the patient wants to do? Who knows what the patient wants to say to the hospital? Who knows what the patient will be able to tell others?

When we ask: "who knows what the patient understands?" we need to ask "who knows how to find out what the patient wants to understand?" There are knowledge, skills, and abilities in this audience, obviously demonstrated, which show that you can find out ways in which you can learn what the patient wants to understand.

Who knows how to help the patient verbalize? Patients who ordinarily are very articulate in a normal situation become practically mute when in the typical clinical setting. Frequently the patient needs to be encouraged to express what he wants to understand. You may need to help him so that he can tell others certain things about his illness and what he needs to do about it.

We need to know when it's best to get the patient's attention, when it's best to get the family involved, and when it's best to get the attention of the hospital and the various people working in the hospital.

Just as the hospital has the responsibility for recording the medication, physical therapy, and laboratory tests given the patient, ultimately we must find a way of maintaining a record of the educational interchange that has taken place between the patient and the hospital.

Ideally, we should know the patient's orientation to his own illness when he was admitted, the questions that were raised, and the answers that were given. It would be useful when the patient is later readmitted for the hospital to know about the earlier educational interchange, to find out how much of it is recalled or what additional reinforcement would be desirable in terms of correcting the impression of the patient.

Obviously, hospitals are complex institutions that have an obligation to serve the community properly while still remaining financially solvent. Administrators are therefore interested in the reimbursement potential for various activities. If a case is not made to show how the hospital will get reimbursed for a cost, then it is more difficult to create interest in the proposal.

With this as our hypothesis, the Hill-Burton program recently called a meeting attended by representatives of agencies both within and outside of government. Agencies and groups represented include Social Security Administration, Social Rehabilitation Service, American Medical Association, American Hospital Association, Blue Cross, and the Health Insurance Council. This group agreed that physicians should be able to write an educational prescription in exactly the same way that they write a drug prescription. Once the prescription has been filled, the hospital should be compensated. We are now working on the mechanics of how this might be done. It is generally agreed that although incorporation in floor cost would be acceptable, it will probably be better handled on a specific basis.

The suggested criteria for the establishment of a patient education program that would merit the support of insurance carriers is as follows:

1. Hospitals would, at the request of the Administrator, and with the concurrence of the Board of Trustees create a patient education committee comprised of representatives from the medical staff and department heads as appropriate.

2. The function of the patient education committee would be to develop a structured response for each clinical condition for which the committee proposes to offer a patient and/or family educational experience.

3. The patient education committee would function under the full, part-time, or consultant direction of a person that has been trained in educational methodology.

4. The content of each response would have been communicated to the physicians on the staff so that they would know prior to writing Rx's just what the hospital proposes to do.

5. The hospital would have established a fee for each structured response that represents additional services. This is to be computed on the basis of Medicare reimbursement methodology.

6. Physicians would initiate action by writing an educational Rx. It would indicate the subject area in which the patient and/or his family is to be educated.

7. The patient record would show that the educational experience ordered was provided to the patient and/or members of his family.

8. The hospital would incorporate in the patient's bill and show as a specific item the amount charged for the service provided.

In closing, I wish to congratulate all of those who have contributed toward making this workshop such an outstanding success. As I listened to the various plans developed by the workshop teams it occurred to me that each team, in its own unique way, has been able to put text-book theory into real life situations. Don't become discouraged if, in some instances, you may find you will have to modify your plans thereby making it necessary to extend your time frame. It is obvious that your goals are specific and that your ideas are exciting. If you are able to persevere in your determination some great changes will be reported at your October session.

workshop program plans

Workshop Program Plans

Before the workshop, each multidisciplinary team from the health care facilities was requested to determine its target population and the topic area to be covered. During the group sessions at the workshop, the teams developed educational programs to meet the needs of their patient or client group, thus making the plans especially relevant to that particular patient group and organizational setting. At the conclusion of the workshop, each team submitted a written plan that included the goal of the educational program, the specific objectives, the resources (both educational and financial), the educational methods to be used, the program design, and the evaluation techniques. Summaries of each of the team reports follow.

While there may have been alterations since implementation of the plans, they represent a practical format for program planning and development. It is hoped that both participants and other readers of the proceedings will find the various approaches of interest and that some of the ideas presented may be adapted to meet the needs of the reader.

BALTIMORE CITY HOSPITAL
BALTIMORE, MARYLAND

SICKLE CELL ANEMIA

GOAL

To bring about a greater awareness of the character, management, and prognosis of sickle cell anemia by patients and their families. The ultimate goal is to maintain as high a level of health as possible for the sickle cell anemia patients.

OBJECTIVES

- To instruct patients and family concerning characteristics and general progression of the disease.
- To carry out a patient education program whereby patients would demonstrate their ability to manage physical activities during various phases of the disease; to adhere to the medical regimen prescribed by the physician; and to follow a physician-prescribed diet.

RESOURCES--EDUCATIONAL AND FINANCIAL

Human resources will include all members of the Education Department staff in addition to physicians, nurses, and social workers. Literature and visual aids (including a film on the disease) will be sought from existing private and government agencies concerned with the problem. In addition, educational materials will be developed by the hospital's Education Department to meet the needs of the patients. No additional funding is anticipated.

EDUCATIONAL METHODS

Initially, patients with their families will be counseled on a one-to-one basis after which group discussions will be held on such subjects as diet, exercise, and matters relating to the character of the disease. Various audio visual aids and flip charts will be used during the group discussion periods.

PROGRAM DESIGN

After approval has been received from the administration to institute the proposed plan, it will be implemented in three phases:

Phase One: A survey will be made of physicians in the community to determine the prevalence of the disease. Clinics will be held at which time additional cases may be found.

Phase Two: Initial counseling will be undertaken for patients and their families.

Phase Three: A follow-up program will be initiated which will include group discussions involving patients and their families with social workers, nurses, physicians, and members of the hospital's education department.

EVALUATION

Patients will be evaluated in terms of their attitude toward themselves and their ability to manage their physical activities, adhere to their medical regimen, and follow their prescribed diet.

BALTIMORE COUNTY HEALTH DEPARTMENT
TOWSON, MARYLAND

FAMILY PLANNING

GOAL

To provide improved patient education in family planning clinics and decrease program failures--i.e., unintentional pregnancies and dropouts due to dissatisfaction with the selected method or other reasons.

OBJECTIVES

. To provide patients with the necessary information to enable them to:

(a) help select the appropriate method for themselves.

(b) use the method correctly.

(c) seek follow-up care for adverse effects and identify problems which might interfere with the success of the chosen method.

(d) utilize referral information provided by Health Department for other problems.

. To prepare a manual for the nursing staff to use in patient education.

RESOURCES

Printed materials, charts and films from Planned Parenthood organizations, pharmaceutical companies, DHEW, and the Maryland State Department

of Health and Mental Hygiene will be used. Public health nurses, clinicians, mental health consultants, health and family planning nurse specialists, and program directors in County and State health departments will be consultants and human resources for the program. Samples of contraceptives will be made available. Financial assistance will be sought from County, State, and Federal Governments.

EDUCATIONAL METHODS

Group discussions as well as individual instruction and counseling will be available to patients. Lectures, demonstrations, films, charts, and printed materials will be available in the clinics.

PROGRAM DESIGN

Upon return to the Health Department, plans for the project will be explained to the appropriate administrators and program directors to gain their support. Material suited to patient teaching will be collected after which a Department committee will select items to be included in a patient education manual. The manual will then be developed by a nursing committee. Nursing staff will then be instructed concerning the use of the manual as a teaching tool to be used in clinics. Instruction will also be given staff on methods for evaluating both the manual and progress of patients.

EVALUATION

On each follow-up visit, the nurse will evaluate the patient's use of the selected method. Continuous monitoring of the manual and its use by nurses will take place so that an evaluation can be made of the success of the manual as a teaching tool. Comparison will be made in the number of "program failures" in the fiscal year following implementation.

BOYS VILLAGE
CHELTENHAM, MARYLAND

PRE-RELEASE COUNSELING PROGRAM

GOAL

To bring about a better adjustment of the youth from Boys Village when they return to community and family life. This would be accomplished through creating an awareness among the youth concerning community agencies which would be encouraged to provide adequate follow-up programs.

OBJECTIVES

. To acquaint youths with community resources.

. To teach each boy how to use community resources to fit his individual needs.

RESOURCES--EDUCATIONAL AND FINANCIAL

Resource personnel will be drawn from the following National, State, and local agencies: U.S. Department of Health, Education, and Welfare; North Central Community Mental Health and Alcoholism Center; Inner City Community Mental Health Center; Baltimore County Health Department; Montgomery County and Prince Georges County Departments of Social Services and Human Resources; and Boards of Education in Montgomery and Prince Georges Counties.

Directories will be developed to supplement those already existing which give information regarding jobs, schools, and locations for free physical examinations. Pamphlets from organizations such as Department of Health, Education, and Welfare; Maryland State Department of Health and Mental Hygiene; and voluntary health groups will be given to the boys on release.

EDUCATIONAL METHODS

Group discussion periods will be planned. These will be supplemented by one-to-one teaching sessions. Team counseling as well as one-to-one counseling or both will also be made available when necessary. Visual aids will be used in the teaching process. Lectures by guest speakers would be included in the overall plan.

PROGRAM DESIGN

The staff will make Pre-Release Services available for boys 14½-16 years old, within 30 days before discharge. Then family contact will be made through Aftercare Workers. Consultation also will be provided to community agencies as to the type of follow-up program that would be appropriate for the youth. The plan is to be implemented as soon as possible.

EVALUATION

Immediate and periodic follow-up of the youths will be made after they return to normal living. It is anticipated that the community agencies will assist in the follow-up after consultation by the Boys Village staff.

HOLY CROSS HOSPITAL
HOME CARE DEPARTMENT
SILVER SPRING, MARYLAND

EDUCATION PROGRAM FOR PATIENTS WITH SPINAL CORD INJURIES

GOAL

To enable paraplegic and quadriplegic patients to be as independent as possible in their home environment.

OBJECTIVE

To design a plan which enables home care patients to identify and solve future health and psycho-social problems and to care for themselves to the greatest extent possible as the result of a comprehensive self-care training program.

RESOURCES--EDUCATIONAL AND FINANCIAL

Financial resources for patient care will be provided through third party payer plans including health insurance plans and State and Federal programs.

Human resources for the educational component will include the physician, public health nurse, the patients' families, rehabilitation workers, occupational therapists and the other health workers involved in the care of the patient.

Organization resources will include those for paraplegics, vocational rehabilitation services, and other voluntary agencies.

Audiovisual aids, charts, and films will be furnished by Vocational Rehabilitation Services.

EDUCATIONAL METHODS

Patients and their families will be involved in group discussions, demonstrations, one-to-one tutoring conducted by public health nurses and other health workers and patients' families. Coaching and talks by older paraplegics will add to the patients' learning experience and morale. Visual aids will include flip charts on diet needs and catheter care.

PROGRAM DESIGN

The program will be carried out by providing instruction to patients on the following topics:

- Psycho-Social needs: (a) readiness and willingness to learn, (b) acceptance of change in body image, and (c) interpersonal relationships.

- Hazards of immobility: (a) cardiovascular complications, edema, fatigue; (b) respiratory complications, inability to cough; (c) gastro-intestinal complications, need to maintain nutritionally sound diet, feed self, prepare food or assist with feeding, need to maintain appropriate weight level; (d) genitourinary problems, bladder management, sexual adjustment; (e) musculo-skeletal problems, practicing wheel chair or other devices, body alignment; and (f) central nervous system problems, pain, lack of sensation of affected areas.

- Safety factors to prevent further damage: (a) locking wheel chair, (b) safe use of circo-electrical bed, and (c) safe transferring techniques and information.

Patients and families as well as community organizations, public health nurse, and other health workers will implement the program.

EVALUATION

Evaluation of the teaching program and patients' progrss will be made by the public health nurses, occupational therapist, and patients' families on a periodic schedule.

HOLY CROSS HOSPITAL (POST MYOCARDIAL INFARCTION)
SILVER SPRING, MARYLAND

EDUCATION OF POST MYOCARDIAL INFARCTION PATIENTS

GOAL

To enable the post myocardial infarction patients to make necessary adjustments in their life style (i.e., following a prescribed regimen) which should prove beneficial to their health following discharge from the Coronary Care Unit.

OBJECTIVES

To establish an education program which will:

- Help patients have a better understanding of the meaning of a "heart attack," what is involved in the healing process, why reduced activity is necessary, and why specific foods are restricted on their diet.

- Provide the patient's family with the information and support that they need to help the patient satisfactorily adjust to the environment outside the hospital.

- Help the patient's family take the responsibility for carrying out health measures that will keep the patient within optimum state of health.

RESOURCES--EDUCATIONAL AND FINANCIAL

Human resources will include the services of the physician, cardiovascular nurse specialists, and dietitian. The Montgomery County Heart Association will also serve as another resource for information, films, charts, posters, brochures, and diet plans.

EDUCATIONAL METHODS

Educational methods will consist of formal and informal classes and individual teaching. The use of audiovisuals, flip charts, pamphlets, and posters will also aid in teaching patients.

PROGRAM DESIGN

During the first week after the conference the team will share with the cardiovascular disease instructors and dietary department members the proposed program, the feasibility of implementing the program, and the necessary channels to receive full support.

The second and third weeks will be devoted to motivating and educating the staff on the seventh floor as a reinforcement area.

The third and fourth weeks will be spent designing and planning six areas of post myocardial infarction instruction: the meaning of heart attack, proper diet, medications, exercise and activity, preventive measures, and utilization of health resources.

All members of the health team such as the pharmacists, licensed practical nurses, part-time auxiliary workers within the hospital, and personnel from community health organizations and the Maryland State Department of Health and Mental Hygiene will participate in the program. Families will be involved in consultation and programs to aid the patients' physical and mental well being.

EVALUATION

Follow-up will be made of patients' progress both on inpatient and outpatient basis by the physician, nurse, dietitian, and other health workers.

HEALTH EDUCATION CORPS PROJECT
GREENVILLE COUNTY PUBLIC HEALTH DEPARTMENT
GREENVILLE, SOUTH CAROLINA

VENEREAL DISEASE PATIENT EDUCATION

GOAL

To reduce the rate of recidivism among persons who have had venereal disease.

To increase the number of patients who keep the follow-up visit appointment.

OBJECTIVES

To demonstrate that the patient education activity will maintain at the 80 percent level knowledge of (1) signs, symptoms and dangers of venereal disease; (2) treatment procedures; (3) methods of transmission of the disease; and (4) ways to prevent the disease.

RESOURCES

A health educator already employed will be giving one-half of his time to the patient education activity.

A locally developed flip chart and slide series will be used in the teaching.

EDUCATIONAL METHODS

A questionnaire to test patient's knowledge will be developed and utilized. Lectures, group discussions, and discussions involving the flip chart and the slide series developed locally to fit the needs of patients will be included.

PROGRAM DESIGN

A control group of 25 patients will have routine venereal disease investigative work and treatments completed for them. There will be three Experimental Groups of 25 patients each. The activity with each of these groups will vary. In addition to the routine VDI as with the control group, the first group will take part in a 30-minute guided discussion with the Health Educator; the second group will have the guided discussion by a patient from Group I and the Health Educator; the third group will have the guided discussion by a patient only.

EVALUATION

The evaluation phase will extend from June 1973 through June 1974.

INNER CITY COMMUNITY MENTAL HEALTH CENTER
BALTIMORE, MARYLAND

ENCOURAGE SELF OR FAMILY REFERRAL TO EMERGENCY SERVICE FOR CRISIS INTERVENTION TREATMENT

GOAL

To increase the number of self and/or family referrals from a defined portion of the catchment area of 36,000 people.

OBJECTIVES

- To educate the community regarding natural crisis points in every person's life.
- To educate the community regarding accidental crisis points that can occur in a person's life.
- To make the public aware of where to go for assistance in mastering crisis situations.

(Anticipated spinoffs include: early recognition by family and/or individual of potential danger points; less need for hospitalization; shorter treatment period; higher individual motivation for treatment; and more appropriate referrals.)

RESOURCES AND METHODS

An effort will be made to educate the larger community through the cooperation of small community groups such as the Neighborhood Advisory Council, Inc., Model Cities, Community Action Agency, Legal Aid, and Housing and Community Development. A representative from each of the community groups will be selected to form a steering committee which will oversee the activities of subcommittees. After a training period during which time members are instructed concerning accidental and natural crisis points in life, they will return to their community groups and instruct interested members who in turn will help in the educational program for the community at large. This committee will meet every 2 weeks to evaluate its activities and progress.

The educational process will take place at all group levels through the use of small group discussions, role playing, pamphlets, and audiovisual aids.

PROGRAM DESIGN

Within the next two weeks the program will be formalized in writing and presented to the administration.

During the month of June the committee will be appointed, materials gathered, and appointments will be set up with community groups.

During the next six months meetings will be held with community groups who will engage in various activities throughout the community.

Periodic reviews will be made of referral sources. These data will be compared with data collected prior to the onset of this program.

EVALUATION

At the end of each month an evaluation will be made of statistical reports from the Emergency Service. Any changes in self and family referrals from that defined portion of the catchment area will be noted.

JOHNS HOPKINS HOSPITAL
WOMAN'S CLINIC (ANTEPARTUM-INPATIENT AREA)
BALTIMORE, MARYLAND

PATIENT EDUCATION FOR HOSPITALIZED
TEENAGERS REQUIRING ANTEPARTUM CARE

GOAL

To maintain as healthy a pregnancy as possible.

OBJECTIVES

The patient will be able to:

. Verbalize her understanding of why she was hospitalized.

. Adhere to a dietary regimen which would reflect measurable loss in weight and edema.

. Collect urine specimens accurately.

. Demonstrate an observable interest in her personal hygiene and personal care.

. Remain in bed as ordered.

. Respond positively to instructions and information given during labor and delivery.

Other objectives will be developed as the program progresses.

RESOURCES--EDUCATIONAL AND FINANCIAL

The program will require the services of various members of the existing hospital staff including administration, physicians, nurses, dietitian, and social worker.

EDUCATIONAL METHODS

Group discussions, movies, visual aids such as pamphlets and flip charts. Individual reinforcement and/or follow-up on a one-to-one basis will be done by various staff members.

PROGRAM DESIGN

- During the first week following this workshop, the workshop team will present the proposed program to the assistant director of nursing in the Woman's Clinic and the Supervisory Staff.

- Within the next month, team members and resource persons will prepare in detail the outlines and material to be covered for each group discussion on such topics as anatomy and physiology, nutrition, the rationale for specific treatment, and the personal hygiene of pregnancy.

- During the fifth week, team members will present their program and outlines to the chief residents for their review and comment.

- During the fifth or sixth weeks, recommended revisions to the program will be made.

- During the sixth and seventh weeks, the team members will present their program to the entire staff. This will be repeated before small groups so that all shifts will be included. Role playing will be among the techniques to be used. Discussions will be held so as to:

    a. Give an overview of the goals and program.

    b. Outline specific material to be covered.

    c. Explain the responsibility of all staff members in terms of implementation, follow-up, and evaluation.

- During the eighth week, classes for the antepartum patients will be held one-hour daily over a 5-day period. The discussion will be led by appropriate staff members. The family may wish to attend the class relating to nutrition. Other topics include: Pregnancy, Treatment, Personal Hygiene of Pregnancy, and Labor/Delivery.

A check list form will be devised to facilitate record-keeping. If a class is missed the patient will be able to attend the following week since her length of stay usually covers a period of more than a week.

EVALUATION

Immediate evaluation will be made by staff members based on their observation of patient reaction and acceptance of hospital regimen and on patient participation in group discussions. Further evaluation will be done by a statistical analysis of readmission rate and length of stay. Records of the patients attending the program will be compared with records of others or a control group.

FUTURE OUTLOOK

If the program proves successful we would hope to show the need for such instruction in the outpatient department. Possibly this could preclude the need for the first hospitalization.

After the team and staff members have become experienced in leading group discussions we would hope to include all hospitalized antepartum patients and then to plan a formalized program for the postpartum patient.

JOHNS HOPKINS HOSPITAL
(ORTHOPEDIC DIVISION)
BALTIMORE, MARYLAND

TEACHING PROGRAM FOR HIP REPLACEMENT PATIENTS

GOAL

To provide an education program on pre- and post-operative nursing management so that the patient undergoing total hip replacement will have a fuller understanding of the role he and his family can play during his recovery.

OBJECTIVES

. Increased responsibility of patient for his own care.

. Involvement of multidisciplinary personnel in program.

. Alleviation of post-operative complications.

. Reduce length of hospital stay.

RESOURCES--EDUCATIONAL AND FINANCIAL

Hospital personnel will be utilized in carrying out this program. No additional expenditures are envisioned.

EDUCATIONAL METHODS

Instruction will be provided on a one-to-one basis, through group discussions, an audio-visual program, and written printed supplements.

PROGRAM DESIGN

- Prior to the operation, the nurse or other member of the training team will hold a discussion with the patient and his family covering various aspects of the surgery and the post operative care that will be required.

- The night before surgery, a member of the training team (probably the nurse) will have a follow-up reinforcement session with the patient at his bedside. This will not include the family.

- Following the operation a representative of the training team will provide routine information to the patient and the family and will provide any explanation which might be needed.

- Daily reinforcement will be provided, as necessary, to the patient and his family.

- Several days before discharge another session will be conducted by appropriate staff members for the patient and his family. In addition to the verbal instructions, the patient will be provided printed instructions which he should follow after discharge.

EVALUATION

The effectiveness of project will be evaluated through such mechanisms as patient questionnaires, observance of patients' performance, and examination of patients' records noting, among other things, whether there is a decrease in the length of stay.

MT. WILSON STATE HOSPITAL
MT. WILSON, MARYLAND

PATIENT EDUCATION FOR TUBERCULOUS PATIENTS

GOAL

To provide a carefully designed educational program for the target group of 15 newly admitted males having a diagnosis of suspected tuberculosis. Upon discharge the patients should have sufficient knowledge of their health problem to successfully maintain their health, thus precluding the need for readmissions. Patients will be selected on a random basis with no regard to age or socio-economic background.

OBJECTIVES

The patient will be able to:

- Identify his prescribed drugs, their purpose, and potential reactions so as to more readily understand why his medical regimen must be followed.
- Understand the basis for prescribed medical procedures so as to allay his anxiety and encourage his acceptance of those procedures.
- Recognize those factors relating to the effects and communicability of tuberculosis and the influence of diet, rest, alcohol consumption, exercise, and personal hygiene.
- Recognize the family's role in providing the needed support and encouragement.
- Distinguish between fact and fiction on health matters.
- Become aware of the community's resources which may be helpful to him.

RESOURCES--EDUCATIONAL AND FINANCIAL

No additional financing will be required, as various health professionals now on the hospital staff or representatives of a government health agency will serve as resource persons. Among those to provide instruction, guidance, counseling, and support are physicians, pharmacists, nurses, dietitian, alcoholism counselor, social worker, physical and occupational therapists, and social service personnel. These persons will be called upon, as needed, to provide the necessary inservice education.

EDUCATIONAL METHODS

Both the one-to-one approach and group instruction methods will be used, as appropriate. Materials will include posters, exhibits, pamphlets, films, flow charts, and written instructions.

PROGRAM DESIGN

The workshop team will request the hospital administrator to call a meeting of all department heads at which time the proposed project will be explained. If active administrative support is indicated, a patient education coordinator will be designated to be responsible for integrating the necessary resources; instituting planning procedures; advising staff of the goals, objectives, and procedures; and overseeing the entire project. It is essential that there be total involvement of a multidisciplinary team.

The educational process will begin when the patient is admitted. Upon arrival at the hospital, the new patient and his family will be greeted in the lobby by the admissions clerk who will take them to the admissions office. The patient and his family will be advised of the admission process after which admission forms will be completed. They will then be given an orientation to the hospital and its surroundings. An evaluation will be made of the patient's attitude toward hospitalization and his knowledge concerning his condition. At this time, the patient will be advised concerning succeeding steps to be taken during the initial phase of his hospitalization. The family is referred to social service.

The admission clerk then takes the patient to his floor where he is greeted by his nurse and taken to his room. At this time he is given an introductory packet with pamphlets on tuberculosis, alcoholism, patients' bill of rights, and a statement of the hospital's rules and regulations.

Next, the patient is taken to the admission doctor's office where the admission physical is given along with an explanation of the orders the physician will write for blood work, X-ray, and medication.

The admission doctor assures the patient that the physician assigned to his floor will follow through with his treatment and further explanation.

Within 48 hours, the dietitian will see the patient to complete the nutritional assessment.

After each discipline has evaluated the patient (taking into consideration his intellectual status, economic resources and particular needs), a joint conference will be held to formulate a comprehensive treatment and educational prescription. This latter prescription will be placed in the patient's chart. Each discipline will be responsible for implementing the appropriate portions of the educational prescription.

Should any change of diagnosis or any untoward reaction develop, another conference shall be held to reevaluate the situation.

EVALUATION

Approximately two weeks prior to discharge, a conference shall be held to evaluate the effectiveness of the educational prescription.

MONTGOMERY COUNTY HEALTH DEPARTMENT
SILVER SPRING HEALTH CENTER
SILVER SPRING, MARYLAND

PREVENTION OF NUTRITIONAL ANEMIA IN CHILDREN

GOAL

To develop an educational program designed to reduce the incidence of nutritional anemia in children aged 1-6 years. In most cases, the children's mothers or a responsible adult (the target population) are limited in their health knowledge and ability to communicate since they are foreign born.

OBJECTIVES

To familiarize target population with the condition of nutritional anemia.

To help target population to formulate meal plans utilizing foods with iron content necessary to meet recommended dietary allowance.

RESOURCES--EDUCATIONAL AND FINANCIAL

Human resources will include public health nurses, nutritionist, physician, health educator, and volunteers. Educational tools will include posters, flip charts, pamphlets, or printed matter. Financing will be made available from the existing budget.

EDUCATIONAL METHODS

Guided discussion for individual counseling and group discussions will be led by nurse and nutritionists.

PROGRAM DESIGN

The program will be initiated by a nurse and nutritionist who will organize several discussion groups for the mothers. A different group will meet on the fourth Tuesday of each month. The nurse will present a short simple explanation of nutritional anemia and the nutritionist will then discuss iron-rich foods, menu plans, methods of preparation, and purchasing tips. Mothers will be encouraged to freely express whatever concerns they may have during the discussion periods.

A checklist will be developed noting symptoms, behavior, and eating habits related to nutritional anemia. During each group discussion period, the target population will complete the checklist, blood samples will be drawn from the children, and the educational program will be presented. The blood level will be noted, and those with abnormally low hematocrits will be treated with iron as usual.

EVALUATION

Observation will be made of the interest and response of the target group during each clinic. One month after the program is initiated, the public health nurse will contact the target population who will again fill out their check lists. In six months another hematocrit will be drawn.

Final evaluation will be made at the end of six months when hematocrits and checklists will be reviewed and compared.

NORTH CENTRAL COMMUNITY MENTAL HEALTH
AND ALCOHOLISM CENTER, INC.
BALTIMORE, MARYLAND

REDUCING THE DROPOUT RATE OF AFTER-CARE PATIENTS

GOAL

To reduce the dropout rate of after-care patients.

OBJECTIVES

- To change admission procedure from agency-orientation to patient-orientation.
- To prepare in lay terms a brochure for patients and families as a home reference.
- To initiate a follow-up outreach program for missed appointments, social problems, medical problems, and other needs.
- To create better human relations with staff, patients, and patients' families.

RESOURCES--EDUCATIONAL AND FINANCIAL

Human resources will include the physician, mental health technician, outreach worker, and social worker. They will be drawn from Mental Health agencies and the Maryland State Department of Health and Mental Hygiene.

EDUCATIONAL METHOD

The teaching methods will include group discussion and one-to-one instruction by physicians, mental health technicians, and community service specialist. Brochures directed at helping patients and their families will be used.

PROGRAM DESIGN

The program design, among other things, sets forth financial arrangements, steps to be followed by the patient and his family, and involvement of physicians. It calls for:

- Initiating face-to-face contact with mental health technicians who will try to comfort the patient during his first visit by listening to his complaints and his expectations of the needed services.
- Initiating a face-to-face contact with the physician for further orientation to the Center and explanation of medication and possible side effects.
- Orientating the patient as to the need for ongoing treatment and medication. This will be carried out by the mental health technician.
- Establishing a mutual agreement concerning the treatment plan, financial arrangements, requests for family involvement with community service specialist and the use of community resources.

EVALUATION

The program will be evaluated by comparing the number of dropouts following implementation and during a certain period of time with the dropout rate for the same months of last year.

PERRING PARKWAY NURSING HOME
EDGEWOOD NURSING HOME
VALLEY VIEW NURSING HOME
BALTIMORE, MARYLAND

ORIENTATION FOR NEW PATIENTS

GOALS

- To orient new patients and their families to the nursing home procedures.
- To orient referring hospitals to the rules, regulations, and procedures of Perring Parkway, Edgewood, and Valley View Nursing Homes.

OBJECTIVES

- To acquaint each non-senile, mobile new patient and his family with the purpose of his admission, the daily routine, the individual patient's nursing care program, the diet, the availability of services such as social services and physical therapy, and the physical plant.

- To acquaint the appropriate staff of the referring hospitals with the nursing home facilities, and the need for understanding the patient's emotional trauma upon his admission.

RESOURCES--EDUCATIONAL AND FINANCIAL

All nursing home professional consultants, private physicians, house staff, directors of nursing service and their patient care staff, the team that attended the workshop, administrators, a few experienced patients, and families will be involved initially. From outside the nursing home, the licensing surveyors and the educational resources of the State and Federal Government will be utilized as consultants. Films from the State Film Library will be shown when practical.

EDUCATIONAL METHODS

Both individual teaching by the Licensed Practical Nurse and the dietary aide as well as group teaching sessions led by the social worker will be included. Tours for ambulatory patients will be conducted by patients within the nursing home and the adjacent community. Pamphlets will be developed internally and others available from voluntary associations will be used.

PROGRAM DESIGN

During the first two weeks the workshop team will establish the specific components of the program which will be explained to the administrators in an effort to obtain their endorsement. During the next two weeks the teams will meet with the directors of departments and the nursing staff who will be asked to assist in developing the program. Staff and long-term patients will be taught and given responsibilities. The written pamphlets will be developed. Work will begin with the evaluation procedures included in the plans.

During the eighth week the program design will be presented and interpreted to those involved in the teaching program. Inservice group sessions will then begin and outside consultants will be involved. The work will be critiqued by inside and outside groups. Then the orientation program will be underway with the patients and their families.

PRINCE GEORGES COUNTY HEALTH DEPARTMENT
JOHN CARROLL CLINIC
CHEVERLY, MARYLAND

COMMUNITY CHILD HEALTH SERVICE

GOAL

To improve the health of the children who are served by the Comprehensive Child Health Clinic by increasing patient utilization of the multidisciplinary services available.

OBJECTIVES

- To encourage and emphasize to parents/guardians the importance of keeping appointments in preventive health care clinics for children.
- To teach the parents/guardians to be able to request the service from the appropriate professional to meet a specific need.
- To help the parents/guardians to be able to express in lay terms the reason for each procedure his child receives at the clinic.

RESOURCES--EDUCATIONAL AND FINANCIAL

The expertise of each member of the clinic's interdisciplinary team is available for services and consultation to all children. Other available resources include: services of the Health Education Staff, Title XIX funds for educational materials, free educational materials, and audiovisual equipment.

Staff training and patient surveys will be developed later.

EDUCATIONAL METHODS

Parents/guardians attending the center will be involved in small group sessions, individual teaching, one-to-one consultation at the clinic and on home visits, role playing demonstrations, and audiovisual displays.

PROGRAM DESIGN

Included in the program plan will be the preparation of a patient survey, a display of photos of clinic activities to help identify staff, a discussion of procedures used with each child, and the initiation of an orientation program for new patients. The plan will also incorporate ways to improve human relations between staff and patients.

EVALUATION

The workshop team will meet May 25 with the Health Educator and Clinic staff to implement the outlined tasks. Monthly committee meetings of the interdisciplinary clinic teams will be held to report on individual cases and to evaluate procedures and the patient survey questionnaire.

ROSEWOOD STATE HOSPITAL
OWINGS MILLS, MARYLAND

A PILOT PROJECT FOR 50 MALES (RETARDED) AGES 11-21

GOAL

To educate a group of retarded males to become more self-sufficient in personal hygiene as an initial step to earlier return to their home environment.

A sub-goal is to reduce the incidence of health problems (e.g., shigella) resulting from poor personal hygiene.

OBJECTIVE

To initiate a program of two self-help skills that will enable the target group to demonstrate their mastery of minimum socially acceptable habits as a step toward enhancing self-concept and esteem.

When the young men complete this program, they will be able to demonstrate the following two self-help skills:

. Toileting.--They will be able to (a) associate those symptoms that indicate the need to go to the bathroom; (b) distinguish a bathroom from other living units; (c) properly prepare himself; (d) demonstrate proper use of toilet tissue; (e) recall the step of flushing the toilet; and (f) wash hands.

. Dental Care.--(a) identify toothbrush, (b) apply toothpaste, (c) brush teeth, and (d) return toothbrush to proper place.

RESOURCES--EDUCATIONAL AND FINANCIAL

No additional appropriations are anticipated to be needed since the program will be carried out by currently employed staff who will utilize existing facilities and equipment.

The health team will include personnel from the cottage staff, nurse, social worker, teacher, physician, psychologist, rehabilitation therapist, dietary aide, nursing education staff, school faculty, chaplain, and volunteers. Additional support will be provided by community organizations, families, a patient education committee, and consultant services. Facilities to be utilized include school classrooms, the residential unit, and the school library. A skills-learned scale will be developed to measure the progress being made.

EDUCATIONAL METHODS

Educational methods will include demonstrations, individual tutoring, group interaction, daily practice exercises, teaching machines, and audiovisual aids.

PROGRAM DESIGN

Initiate Program Planning.

Objective.--Good personal hygiene is of vital importance if an individual is to perform satisfactorily in all aspects of day-to-day living. The necessity for personal hygiene remains high regardless of the mental or physical status of the individual concerned. With this need in mind, a program will be developed to reach 50 percent of trainable retarded males in the cottage. Instruction will be given on the significance of personal hygiene in relation to maintaining physical health.

Background.--Patients, ranging in age from 11 to 21 years, are from a variety of socio-economic backgrounds. They previously lived in Baltimore and the 23 counties of Maryland. The patients have had minimum educational exposure, and they function at a low level. They do not understand the nature of their physical condition.

The patients have been confronted most of their community life with feelings of inadequacy, low self-esteem, and rejection. Hospitalization has not increased the patients' perception of his adequacy and worth; instead, it has tended to further impose dehumanizing experiences. (Mass living, lack of individual attention, no privacy, no establishment of expectations in performance, and no goal setting.) His beliefs and perceptions are usually molded by piers, cottage staff, and inadequate living facilities.

The patients reside in the institution on a 24-hour-a-day basis, generally seven days a week until maximum age or training for his unit is reached. There is ample time in the patients' schedule for health education. However, the low functioning of this group prevents any degree of real understanding of the nature of their condition.

Methodology.--The initial step is to present the plan to top administration. Following approval, orientation sessions will be held for the total staff, and reinforcement sessions will be held as necessary. Staff members will be delegated specific responsibilities. The educational needs of the target group will be determined, based on their physical limitations and ability to comply with the proposed programs. A similar group of patients will be observed to compare the extent of change. The team will hold weekly meetings to discuss problems and progress.

As reinforcement for the target group, special rewards will be offered through special treats, body language, and outside trips. Special recognition will also be given staff for their participation in the program.

Teaching Materials.--These will include a mannequin, slides and other audiovisual aids, posters, and specific items related to what is being taught such as the toothbrush and toothpaste.

Evaluation.--Evaluation will be carried out through observation of behavior changes, written reports, and comparison with similar groups.

SACRED HEART HOSPITAL
CUMBERLAND, MARYLAND

CARE FOR POST MYOCARDIAL INFARCTION PATIENT

GOAL

To have the myocardial infarction patient carry out good health practices which will help him achieve his maximum health potential following discharge from the coronary care unit.

OBJECTIVES

The patient should be able to:

. Verbalize the meaning of a heart attack.

. Regulate his activity by taking his own pulse.

. Select his menu appropriate to his prescribed diet.

. Know his medication by name and what it does.

RESOURCES--EDUCATIONAL AND FINANCIAL

All Intensive Care and Post Coronary Care personnel who with the attending physicians would be involved. In addition, the pharmacist, dietitian, patient care coordinator, and the Heart Association will be utilized as resources.

EDUCATIONAL METHODS

Flip charts, the film "My Heart Attack," pamphlets, posters, and dietary instruction sheets will be part of the visual aids. Small group discussions will be held, where feasible.

PROGRAM DESIGN

A report of the workshop will be made early in May to the Cardiac Rehabilitation committee. This will be followed by conferences with the Medical Advisor for Progressive Coronary Care so that the staff teaching program and the patient teaching outlines can be developed. Classes in cardiac nursing have been attended on a continuing basis at universities by staff so that it is anticipated that the plan could begin early in June.

Community resources and health agencies will be asked to participate in the follow-up care.

EVALUATION

One week after discharge the nurses and the patient care coordinator will contact the patients by telephone to ascertain their progress. Approximately 6-8 weeks after discharge a "graduate" class will be held for reevaluation and assistance with problems. Additional learning experiences will be included. A log book will be maintained on the unit for evaluation of readmission statistics.

The patient's progress will be recorded on an assessment sheet which will become part of his permanent record at the hospital as well as at home. At the hospital this record also will document the effectiveness of the teaching program.

SACRED HEART HOSPITAL
CUMBERLAND, MARYLAND

EDUCATION OF COLOSTOMY PATIENTS

GOAL

To assist the colostomy patient to make an independent transition from the hospital to the home. Future goals involve setting up pre- and

post-operative teaching programs that will later expand into chronic illness areas. A secondary goal is to establish a program for teaching staff.

OBJECTIVES

To teach the colostomy patient to:

. Verbalize the meaning of colostomy.

. Change his colostomy bag.

. Select his own equipment.

. Select prescribed foods.

RESOURCES--EDUCATIONAL AND FINANCIAL

Human resources would include those involved in the care of the patient: the physician, nurse, and dietitian, Patient Care Coordinator, the surgical supply agent, and possibly members of the Tri-State Ostomy Association. Financial assistance would be secured through the budget of the hospital's Inservice Education Program.

PROGRAM DESIGN

A report of the workshop will be made early in May to the Cardiac Rehabilitation committee. This will be followed by conferences with the Medical Advisor for Progressive Coronary Care so that the staff teaching program and the patient teaching outlines can be developed. Classes in cardiac nursing have been attended on a continuing basis at universities by staff so that it is anticipated that the plan could begin early in June.

Community resources and health agencies will be asked to participate in the follow-up care.

EVALUATION

One week after discharge the nurses and the patient care coordinator will contact the patients by telephone to ascertain his progress. Six weeks after discharge a "graduate" class will be held for reevaluation and assistance with problems. Additional learning experiences will be included.

The patient's progress will be recorded on an assessment sheet which will become part of his permanent record at the hospital as well as at home. At the hospital this record also will document the effectiveness of the teaching program.

SOUTH COUNTY FAMILY HEALTH CENTER
WEST RIVER, MARYLAND

HEALTH EDUCATION TO PROMOTE HEALTH MAINTENANCE

GOAL

To attain better health for residents of South County through the promotion of increased utilization of health and medical services offered at South County Family Health Center.

OBJECTIVES

- To have an enrollment of 750 households at the end of six months in the utilization of health and medical services at SCFHC (i.e., complete patient education, milk program, well-baby clinic, laboratory services).
- To develop a concern for early detection of illness so that persons with a health problem will seek treatment and care before the illness has progressed.
- To establish a climate in which patients show concern for monitoring their own health status and are motivated to carry out their health regimen.
- To encourage residents without health problems to utilize the clinic's services aimed at health maintenance and disease prevention.

RESOURCES

The program will be carried out by a health team comprised of doctors, nurses, health advocates, social workers, dietitian, family planning aid, youth development coordinator.

Materials to be used will include patient education worksheets, literature from various sources (e.g., the Health Department, drug companies, and health organizations), posters, films, flip charts, tape recorder, reference books, and library.

Community resources from which assistance will be drawn include the Health Department, various health associations, the Red Cross, schools, local businesses, HEW patient education consultant, and volunteers.

EDUCATIONAL METHODS

Some of the educational methods to be used include group discussion, demonstrations, and one-to-one counseling.

PROGRAM DESIGN

. By June 1 develop a tape recording and flip chart explaining the clinic's services and health maintainance. These will be placed in the waiting room and a nurse will explain their use.

. In June, establish a series of prenatal classes.

. By August 1, structure a patient education program covering such topics as, hypertension, prenatal care, diabetes, and stroke. Nurses, LPN's, and health advocates will carry out this program. Counseling will be provided by health advocates trained by the nurse.

. By September establish a weight control program.

SPRINGFIELD STATE HOSPITAL
SYKESVILLE, MARYLAND

MEDICATION EDUCATION FOR THE MENTALLY ILL CLINIC PATIENT

GOAL

To reduce readmissions to the hospital by teaching the patient about his medication and the importance of maintaining a schedule for his medications and his clinic follow-up visits. The target group will be ten readmitted patients.

OBJECTIVES

. To learn the name, dosage, desired effect, frequency of dosage, and side effects of medications prescribed.

. To adhere to the medication regimen as prescribed.

. To keep follow-up appointments in the clinic.

RESOURCES--EDUCATIONAL AND FINANCIAL

The human resources involved in the educational work will be the clinic medical team, the pharmacist, the unit staff treating the patient, and the inservice education staff.

EDUCATIONAL METHODS

Several educational methods will be used. These will include group discussions involving the patient, the pharmacist, the social worker, the nurse, and the mental health aide. A patient questionnaire will be developed for the purpose of ascertaining the patient's knowledge about his medication. Other educational methods will include demonstrations, films, role playing, and individual conversations as requested by the patient.

PROGRAM DESIGN

Group discussions will begin within a week or two after the workshop. Demonstrations, films, and role playing will be used with the groups during the second and third weeks. The fourth week of group discussions will focus on family problems. The cycle of the four week program will be repeated. The patient's folder will need to contain the material from any inpatient care, the questionnaire for inpatient/outpatient evaluation, self-medication reports from nursing, and clinic follow-up reports.

The Clinic follow-up activity will be part of the education program as it utilizes the group get-together, including the family, to teach about the clinic and to help the family units to seek help from the clinic before returning to the hospital.

EVALUATION

Each patient's behavior will be evaluated by studying his responses to the questionnaire, the reports from the nursing staff, the clinic report (team report), the reports from the individual "conversations," and the post-interviews when the patient returns to the clinic for his appointments.

SPRING GROVE STATE HOSPITAL
BALTIMORE COUNTY UNIT
BALTIMORE, MARYLAND

SELF-IDENTIFICATION FOR NEWLY ADMITTED ADOLESCENTS

GOAL

To help adolescent patients accept responsibility for their own behavior and participate in their own treatment plan from the time of admission.

OBJECTIVES

To help the newly admitted adolescent patients:

. Feel important and accepted by staff and peers.

. Identify their specific problems.

. Decide whether or not they need treatment.

. Formulate their treatment plan.

RESOURCES--EDUCATIONAL AND FINANCIAL

Human resources include 10 counselors, the family members, professional personnel such as 2 psychologists and 6 psychiatrists, paraprofessional personnel such as 16 mental health aides and 1 occupational therapist. Material resources include lists of behavior standards, schedules of activities, personal behavior charts, athletic equipment, materials for craft work, and audio visual equipment.

Financial resources include project monies for inservice training of staff, medications, special equipment, and material for patients.

EDUCATIONAL METHODS

Many teaching methods will be used including individual meetings with counselor at least twice a week; contacts with a "buddy," an assigned patient; group meetings with other patients and staff; the use of the assessment techniques reflected in the problem-oriented record; psychodrama; vocational training; job counseling; occupational therapy; and audio and video tape feedback of his own behavior.

PROGRAM DESIGN

While in the Admission Area the patient will make his initial staff contact through an interview and discussion of the orientation pamphlet and will be informed about the "buddy system."

Within the first week in the Unit there will be interviews, phone calls to families, group meetings, and discussion of assessment material through the use of the checklist.

Also within the first week and into the second week there will be interviews with staff and the personal behavior chart will be developed.

At the end of the second week the adolescent, the family, and the staff will consider the plan for the treatment and "formal staffing" will be completed. Educational methods noted above can be carried out in Phase II of the program design.

EVALUATION

Patients will be evaluated through an assessment.

SUBURBAN HOSPITAL ASSOCIATION
BETHESDA, MARYLAND

SELF-CARE PROGRAM FOR DIABETICS

GOAL

To have diabetic patients maintain optimum health thru self care.

OBJECTS

Patients will be able to:

. Select their own menus from food exchange lists.

. Administer their own insulin correctly.

. Use proper technique in urine testing.

RESOURCES

Hospital personnel involved in the program include the dietitian, nurses, physicians, and volunteers.

EDUCATIONAL METHODS

Instruction will be carried out through the one-to-one approach and in small groups. Discussion and demonstration sessions will be held. Materials to be used will include pamphlets, food charts, flip charts and, if possible, films.

PROGRAM DESIGN

. During the week following the Marriottsville meeting, team members will explain the proposed plan to the director of nursing who, in turn, will advise the administrator. Team members will inform physicians of the program.

. At the next regular meeting of head nurses (in about two weeks), team members will explain the proposed plan which will also be explained to other nurses.

. During the following month the staff involved in the teaching program will be trained.

. By the end of the second month, team members and instructors shall have inspected and reviewed resources and materials (including films) to be used.

. Upon completion of all preliminary activities, the program for the patients will begin. This will include a 45-minute program once a week in addition to individual instruction.

. The family will be included during all facets of the teaching program.

EVALUATION

The evaluation program will include observations by physicians and others as well as patient questionnaires.

UNIVERSITY OF MARYLAND HOSPITAL
BALTIMORE, MARYLAND

EDUCATION FOR PATIENTS WITH CHRONIC RENAL FAILURE

GOAL

To help the patient develop the understanding and skills necessary to follow effectively a medical regimen and to communicate his condition to the health care team.

OBJECTIVES

The patient objectives include:

. To understand the medical status and the options available.

. To recognize the importance of monitoring intake and output and the body's fluid balance.

. To recognize signs and symptoms that might indicate change in physiological status.

. To demonstrate proficiency in administration of medication.

. To develop an understanding of the renal diet and the ability to follow it.

. To develop an understanding of hemodialysis and to demonstrate the ability to cooperate with the policies of the unit.

. To demonstrate a proficiency and skill to perform hemodialysis.

. To demonstrate an understanding of the need to cooperate with the health care team.

. To demonstrate the ability to carry on as normal a life pattern as possible.

RESOURCES--EDUCATIONAL AND FINANCIAL

Human resources include physicians, nurses, dietitians, social workers, family members, and the students and instructors on the units.

EDUCATIONAL METHODS

Special emphasis will be placed on individual conferences with the patient and the family. Whenever possible, group discussions will be conducted. Supervised demonstrations and return demonstrations will be planned. Visual aids and printed materials will be used and studied by the patient and the family.

PROGRAM DESIGN

The objectives which have been presented in chronological order will be integrated into the program for each patient in the units. The design was based upon material already developed for training purposes; since this is a teaching hospital the objectives involve students and instructors in both the Inpatient and the Outpatient Renal Disease Programs.

EVALUATION

The patient will be evaluated by his participation in his own medical program. It will be possible to observe, to watch the medication intake, to measure adherence to diet, to test the return demonstration when method is involved, to monitor the procedures, and to measure adherence to schedules and appointments. Motivation is an extremely potent factor in the patient's self-care program because of the limited options available to him.

WASHINGTON COUNTY HEALTH DEPARTMENT
HANCOCK HEALTH CENTER
HAGERSTOWN, MARYLAND

NUTRITION EDUCATION IN THE WELL-BABY CLINIC

GOAL

To improve the health status of families attending the clinic by helping them to achieve optimal food intake patterns. The parents (or guardians) would comprise the target population.

OBJECTIVE

To teach mothers (or guardians) some basic information which would help them to acquire balanced diets for their families on a limited budget.

RESOURCES--EDUCATIONAL AND FINANCIAL

Instruction will be provided by a nutritionist, two staff nurses, and a nutrition program aide from the Expanded Food and Nutrition Program of the Cooperative Extension Service. Health Department and Appalachian Nutrition Project funds can be utilized. Audiovisual equipment and visual aids will be utilized.

EDUCATIONAL METHODS

Mothers (guardians) will be involved in group discussions, in guided instruction in relation to assembled materials, in individual counseling, and in demonstration.

PROGRAM DESIGN

Within two weeks after the Workshop, the team (public health nurse and nutritionist) will meet with key Health Department staff for consultation and approval of the plans.

During the next two months the details of the plan (including the educational methods and materials) will be developed.

At the July clinic, the nutritionist will administer the pre-test and the clinic staff will begin to implement the plan in the clinic setting.

At the August and September clinics, staff will carry out the educational plan with new patients. Follow-up will be provided to the July patients as appropriate by clinic staff.

At the October clinic, the post-test will be administered to the original patients by the nutritionist.

Following evaluation and appropriate modification of the educational plan, it will become an on-going component of the clinic program.

WESTERN MARYLAND STATE HOSPITAL
HAGERSTOWN, MARYLAND

REHABILITATION OF STROKE PATIENTS

GOAL

To rehabilitate each stroke patient to his maximum level while hospitalized and to maintain this level after discharge.

OBJECTIVES

- The hospital staff can explain to the patient and family in elementary terms the definition of a stroke including associated disabilities and the potential for rehabilitation.
- The staff and family participate in the patient's rehabilitation.
- The patient, staff, and family recognize the need for the patient to perform to the limits of his potential.
- The patient participates in his self-care activities.
- The patient applies his self-care skills daily after discharge to home.

RESOURCES

A variety of persons will be involved in carrying out this program. They include hospital medical and nursing staff, consultants, family, members of voluntary organizations, peer groups, volunteers, public health nurse, family physician, physical therapist, and chaplain.

EDUCATIONAL METHODS

Instruction will be carried out through group discussions, demonstrations, dramatization, experimental learning, and individual tutoring. Materials to be used will include anatomical models, films, and literature.

PROGRAM DESIGN

- Upon return to the hospital the education team will present the program plan to the Hospital Director, Acting Director of Nurses, and Inservice Educators.
- Within two weeks the plan will be presented to department heads.
- Within three weeks, a patient education committee will be set up to assess the need, feasibility, and program structure. Patients, families, and staff members will be interviewed during this period.
- Within six weeks the patient education program will be implemented. The Barthel Index (B.I.)* will be used to assess a control group which will consist of discharged stroke patients. Interested professionals will be recruited to trail nonprofessionals who will assist in carrying out an all out patient education campaign which

*The Barthel Index is an objective tool used in chronic disease hospitals to score a patient's self care ability. Developed by Florence Mahoney, M.D., and Dorothea Barthel, P.T., it is used to assess the patient's treatment program and rehabilitation status.

emphasizes self care. All participants will be given an explanation of the Barthel Index. An effort will be made to encourage better communication between staff and family; staff and patient; peer group, patient, and family; and hospital and health agencies (i.e., Health Department for follow-up).

EVALUATION

Within six months, the patient's progress will be assessed. This will be accomplished by comparing the patient's B.I. at the time of discharge with his B.I. after being home for one month. These data will then be compared with those of the control group.

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